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The Role of a Family History of Alcohol or Drug Abuse on PTSD Outcomes Following Community Violence Exposure

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A thesis submitted in partial fulfillment of the requirements for the degree of Master of Science at Virginia Commonwealth University.

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Abstract

THE ROLE OF A FAMILY HISTORY OF ALCOHOL OR DRUG ABUSE ON PTSD OUTCOMES FOLLOWING COMMUNITY VIOLENCE EXPOSURE

by Kathryn Reid-Quiñones, B.A.

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Research consistently has revealed the damaging consequences of children's repeated exposure to community violence and Posttraumatic Stress Disorder (PTSD) is the most commonly cited internalizing disorder associated with such exposure. However, not all children who are exposed to community violence develop PTSD symptoms; thus, it is important to identify factors that contribute to this deleterious relationship. The purpose of the present study was to examine the relation of community violence exposure (CVE) and PTSD in a sample of urban adolescents. Additionally, the study assessed whether a maternal history of alcohol or drug abuse would exacerbate the association of CVE and PTSD symptoms in youth. Furthermore, deficient parenting and poorer psychological functioning of the substance-abusing mother was examined as a possible explanation of the relation of maternal substance abuse to community violence exposure and PTSD. Participants included 309 biological mothers and their 5^{th} or 8^{th} grade children (N = 309 dyads) who were recruited from high-violence neighborhoods in Richmond, Virginia.

Youth and their maternal caregivers completed separate home interviews. Results revealed that greater violence exposure (witnessing violence and direct victimization) was associated with higher levels of PTSD symptoms in youth. Additionally, maternal alcohol abuse history exacerbated the relation between witnessed violence and PTSD symptoms. At low levels of witnessed violence, mother's alcohol use type did not influence PTSD symptoms; however, as levels of witnessed violence increase, youth whose mothers were classified as having a positive alcohol abuse history were more likely to report higher levels of PTSD symptoms. Furthermore, parental knowledge was an independent predictor of PTSD symptoms in each of the models. Lower levels of parental knowledge were associated with higher levels of youth-reported PTSD symptoms. Overall, the study findings support the need to examine moderating and mediating factors of the relation between CVE and PTSD among youth.

Introduction

Only within the past 15 years have researchers begun to focus on the negative effects on children of living in a high violence area. The sheer prevalence of community violence places the issue of children's exposure as high priority. In 1995, Osofsky cited numerous studies that have acknowledged the need for additional research on the long-term effects of violence exposure on children's development. Poor, urban youth are exposed to community violence at incredibly high rates. Studies have reported that approximately 80 percent of urban youth have experienced some form of community violence in their lifetime (Gorman-Smith & Tolan, 1998; Henrich, Schwab-Stone, Fanti, Jones, & Ruchkin, 2004). Minority youth are at an increased risk for exposure to community violence since they are over represented in poor, inner-city neighborhoods. Conditions of poverty make resources necessary for overcoming the detrimental effects of community violence exposure difficult to obtain for these youth.

Research consistently has revealed the damaging consequences of children's repeated exposure to community violence. Youth who are exposed to community violence report experiencing internalizing symptoms, externalizing symptoms, and academic difficulties at higher rates than youth who do not report exposure to community violence. These problems include greater distress symptoms, attachment problems, aggressive behavior, depression, anxiety, academic problems, and social maladjustment (Appleyard & Osofsky; 2003; Barbarin, Richter, & deWet, 2001; Ceballo, Ramirez, Hearn, & Maltese, 2003; Farver, Xu, Eppe, Fernandez, & Schwartz, 2005; Krenichyn, Saegert, & Evans, 2001). In addition to internalizing behavior problems, many studies

have noted the relation between exposure to community violence and externalizing behavior problems including aggression (Buka, Stichick, Birdthistle, & Earls, 2001; Gorman-Tolan, 1998; Moses, 1999; Schwab-Stone, Ayers, Kasprow, Voyce, Barone, & Shriver, 1995) and substance use (Sullivan, Kung, & Farrell, 2004; Kilpatrick, Ruggiero, Acierno, Saunders, Resnick & Best, 2003; Kilpatrick, Acierno, Saunders, Resnick, Best, & Schnurr, 2000; Schwab-Stone et al., 1995). The wide range of negative outcomes makes it clear that additional research is vital in order to learn which pathways contribute to these effects and how they can be altered.

This relation between violence exposure and behavior problems is not confined to a specific age range of children and the presentation of externalizing behavior changes as children grow. Shahinfar and colleagues (2000) found that in a group of Washington, DC, Head Start preschoolers those children who demonstrated more aggressive and disruptive behaviors were more likely to have been the victims of mild violence. Overstreet (2000) examined an older group of children ranging for age 10 to 15 and found that in this group externalizing behavior problems associated with violence exposure were exhibited through gang membership, deviant peer affiliation, delinquency, and involvement in criminal activity.

With few exceptions (e.g., Farrell & Bruce, 1997), researchers consistently have shown a relation between community violence exposure and internalizing behavior problems in children. Although symptoms of anxiety and depression routinely are associated with community violence exposure (Gorman-Smith & Tolan, 1998; Kliewer, Cunningham, Diehl, Parrish, Walker, Atieyeh, Neace, Duncan, Taylor, & Mejia, 2004;

Kliewer, Lepore, Oskin, & Johnson, 1998; Mazza & Reynolds, 1999; Moses, 1999; Shalimar, Fox, & Leavitt, 2000), the most frequently noted internalizing behavior problem associated with community violence exposure is Posttraumatic Stress Disorder (PTSD) (Berman, Kurtines, Silverman, & Serafini, 1996; Berton & Stabb, 1996; Mazza & Reynolds, 1999; Overstreet & Braun, 2000; Salzinger, Feldman, Stockhammer, & Hood, 2002)

Review of the Literature

Posttraumatic Stress Disorder (PTSD)

Definition of PTSD

Posttraumatic Stress Disorder (PTSD) is a common reaction to traumatic events and is the most frequently noted internalizing behavior problem associated with exposure to community violence. While PTSD has been studied extensively in adults, only within the last 20 years have researchers begun to examine PTSD in children and adolescents. A diagnosis of PTSD is established by the presence of six major criteria. The first two criteria define the experience of a traumatic event. The *DSM-IV-TR* requires that the two following criteria must be met by a person who has been exposed to a traumatic event: "(1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others; (2) the person's response involved intense fear, helplessness, or horror" (2000, p. 467). Additionally, it is noted that a child's response may be displayed as disorganized or agitated behavior (APA, 2000). The resulting symptoms of exposure are then grouped into three clusters: re-experiencing the traumatic event, avoidance trauma-related stimuli and numbing of responsiveness, and hyperarousal. Furthermore, the duration of the symptoms must be greater than one month. Traumatic events can be experienced both directly and indirectly. Direct trauma includes direct threat to the individual's life, whereas an indirect trauma would include events such as hearing about a threat to another person's life, such as hearing about a neighbor being shot. The presentation of symptoms differs between adults and children, with children often re-

experiencing the event in the form of distressing dreams and generalized nightmares as well as repetitive play. In addition, children often manifest assorted physical symptoms, such as stomachaches and headaches (APA, 2000).

Prevalence of PTSD

Community-based studies indicate that the lifetime prevalence for PTSD is about 8 percent for the general U.S. population (APA, 2000). Prevalence rates are considerably higher for individuals who are considered at-risk due to exposure to specific trauma incidents, such as war, rape, and genocide. It is estimated that one-third to more than one half of those exposed to these "high risk" traumas will develop PTSD (APA, 2000). The consequences of PTSD may have greater developmental implications for children and adolescents. Pynoos (1994) highlighted that PTSD causes not only intense emotional suffering, but is a serious disorder in children and adolescents due to its adverse affects on biological, psychological, and social development. Despite the deleterious effects of PTSD on children, no epidemiological studies have determined the prevalence of the disorder in children and adolescents (Davis & Siegel, 2000).

Development of PTSD in Children

A number of researchers have proposed models for the development of PTSD in children and adolescents. The Trauma Accommodation Syndrome is a five-stage stress model for conceptualizing children's adjustment to stressful events proposed by Veltkamp and Miller (1994). In Stage 1 of the model, the child experiences a traumatic event that involves a serious threat to their life or physical well-being, or a serious injury. Stage 2 consists of a response of fear, helplessness, or horror from the child. Stage 3 is

characterized by the child reenacting the trauma through repetitious play, nightmares, and/or avoidance. Recurrent intrusive and distressing recollections of the stressful event, including thoughts or images sometimes accompanied by disorganized or agitated behavior also comprise Stage 3. Stage 4 is distinguished by the presence of cognitive processing in which a triggering life event can lead to reevaluation of reexperiencing or the physical and/or psychological trauma. The ultimate function of Stage 5 is for the child to resolve or accommodate the traumatic experiences, without doubt or guilt, through the use of coping strategies in a manner that permits the child to incorporate adaptively the meaning of the traumatization into his or her identity.

Pynoos (1993) examined the effects of traumatic stress on both proximal and distal development in children. He asserted that the proximal development might be affected by a disruption in the competencies and skills that have recently been acquired by the child. In addition to this, trauma associated avoidance behaviors can impede the child's achievement or autonomy. The distal developmental effects of childhood trauma are thought to affect personality development through changing the child's perceptions of danger, representations of self and others, and regulation of cognitions and affect. Pynoos (1993) also proposed that being exposed to stressful life events in adulthood might serve to reactivate negative self-attributions.

Trauma and Resiliency

Fortunately, not every child exposed to a traumatic event will go on to develop PTSD. Further, an experience that results in a child developing PTSD may not produce the same outcome in another child (Briere, 1997). Researchers refer to these youth with

more positive outcomes as exhibiting resiliency due to their positive outcomes in the face of dangerous, high-risk environments (Brookmeyer et al, 2005). Resilience has been defined as "a dynamic process encompassing positive adaptations within the context of significant adversity" (Luthar, Cicchetti, & Becker, 2000). Two critical conditions have been identified as necessary for the process of resiliency: (1) exposure to significant threat or severe adversity; and (2) the achievement of positive adaptation despite major assaults on the developmental process (Luthar, Cicchetti, & Becker, 2000). The first condition of the definition of resilience shares the requirement of "exposure to a significant threat" with the requirements for the diagnosis of PTSD; the experience is the same, but the individual's response to the event is different.

It is important to identify what factors makes one person adapt positively to such circumstances while another experiences PTSD in order to identify risk and protective factors associated with the disorder. Greater knowledge of how these processes are initiated will allow for more effective interventions that will promote resilience and prevent PTSD outcomes for youth exposed to community violence. Researchers have followed this premise and identified a number of risk factors that appear to moderate the development of PTSD following exposure to trauma. Identified risk factors for developing PTSD include a number of demographic, psychologically-related, and family-oriented factors.

PTSD Risk Factors

Demographic risk factors for PTSD development include proximity to the trauma, gender, and age (Davidson, Inslicht, & Baum, 2000). Proximity to the traumatic event

and having a close relationship with a victim of trauma have been supported as risk factors for PTSD in youth (Pynoos, Frederick, & Nader, 1987). When examining a group of children and adolescents bereaving the death of a parent, Stoppelbein and Greening (2000) found that being female and younger age increased the number of reported PTSD symptoms. Stoppelbein and Greening's (2000) finding that being female places an individual at a higher risk for developing PTSD following exposure to a traumatic event supports the results of other studies examining risk factors for PTSD (Davis & Siegel, 2000; Jaycox, Ebener, Damesek, & Becker, 2004; Linning & Kearney, 2004). In addition to gender, age predicts vulnerability to PTSD. Davidson and Smith (1990) found that PTSD is three times more likely to occur if the trauma is experienced before the age of 11. It has been suggested that younger children are more vulnerable to PTSD because they have not yet developed the strategies to cope effectively with the traumatic event (Scheeringa & Zeanah, 2001). Another possible explanation for increased vulnerability for younger children is that their brains are still undergoing complex changes through adolescence. Steinberg and colleagues (2004) asserted that these changes in the neurobehavioral systems underlying the regulation of emotions and behavior cause patterns of emotional and behavioral problems to become increasingly consolidated and hard to modify. Researchers have suggested that adolescents experiencing psychological trauma during this time of brain maturation can hinder the process of normal development and may produce a regression to earlier stages of development (Pynoos, Steinberg, Ornitz, & Goenjian, 1997).

Individually related personality risks have been identified as risk factors for PTSD development. Lonigan and colleagues (1994) found that the level of anxiety or a child's tendency to experience anxiety or negative emotionality is related to the development of severe PTSD in children. It has been suggested that personality variables may cause some children to put themselves in situations where there is the potential for violence or injury (Davis & Siegel, 2000). Additionally, it has been speculated that differences in coping styles may predispose some children to developing PTSD as a result of trauma (Lynch, 2003). However, due to the lack of clear evidence on individual personality risks, additional research is needed in this area.

Studies have also identified a number of family-oriented risks for PTSD development. Family-oriented risks may be particularly important because they are amenable to change. Linning and Kearney (2004) examined youth living in shelters for sexually and physically maltreated children and found that children diagnosed with PTSD had higher rates of a family history of alcohol or drug use. Additionally, several studies have found that parental PTSD predicts higher rates of PTSD in children after a traumatic event (Famularo, Fenton, Kinscherff, Ayoub, & Barnum, 1994; Pelcovitz et al., 1998; Rossman, Bingham, & Emde, 1997; Sack, Clarke, & Seeley, 1995). In addition to parental PTSD, researchers have identified maternal depressive symptoms (Deblinger, Steer, & Lipmann, 1999), maternal history of any disorder (Cornely & Bromet, 1996) and general psychiatric problems in either parent (Amaya-Jackson & March, 1995; Breton, Valla, & Lambert, 1993) as risk factors for youth development of PTSD. Additional family-oriented risk factors of PTSD development include parenting perceived as

rejecting (Deblinger et al., 1999; Ruchkin, Eisemann, & Haeggloef, 1998) and perceived as inducing guilt and anxiety (Deblinger et al., 1999), and having a father perceived as low on warmth (Ruchkin et al., 1998). Lower levels of parental support of the child have also been found to be risk factors for PTSD in children (Amaya-Jackson & March, 1995; Kliewer et al., 1998; Ozer & Weinstein, 2004; Rossman et al., 1997). Studies show a clear link between parental and family functioning and a child's outcomes after exposure to a traumatic event.

Community Violence Exposure and PTSD

Within the last ten years, researchers have increasingly focused their attention on the relation between community violence exposure and PTSD. In Lynch's (2003) review of the consequence of community violence, he reported that several researchers found positive associations of community violence exposure and symptoms of posttraumatic stress disorder in children ranging in age from early elementary years through adolescence. While all forms of community violence have been associated with negative outcomes, chronic exposure to community violence and personal victimization by violence have the strongest associations with negative outcomes (Lynch & Cicchetti, 1998; Terr, 1991). Lynch and Cicchetti's (1998) research indicated that even after controlling for demographic variables and prior symptomatology, victimization by community violence predicted levels of traumatic stress. Additionally, they found that victimization predicted symptoms of traumatic stress in a sample of urban children who had been maltreated by a caregiver even after the effects of maltreatment severity were controlled. In another study of victimization, Fitzpatrick and Boldizar (1993) reported an

increased risk of PTSD resulting from victimization in females and among children raised in homes with few or no stable male figures present.

Community Violence Exposure and PTSD Rates

While prevalence rates of PTSD are estimated at around 8 percent for the general U.S. population (APA, 2000), prevalence rates for children exposed to trauma including community violence are estimated to range from 21 to 55 percent. Various ranges of PTSD resulting from community violence exposure have been reported in studies of community samples. Boney-McCoy and Finkelhor (1995) reported a moderate effect size (d=.39) for the relation between victimization and PTSD symptoms in a nationally representative sample of 2,000 youth ages 10-16. When Fitzpatrick and Boldizar (1993) examined a sample of 7-18 year olds they found that both witnessing violence and victimization were significantly related to PTSD symptoms; 27 percent of their sample met diagnostic criteria for PTSD. Similarly, Overstreet and colleagues (1999) found that in their sample of 10-15 year olds about one-third of the adolescents who had been exposed to community violence displayed PTSD symptom patterns. Horowitz, Weine, and Jekel (1995) reported that 67 percent of their sample of urban adolescent girls met DSM-III-R criteria for PTSD. It is difficult to compare the rates of PTSD symptomatology in studies of community violence due to different measures of PTSD symptoms and different definitions of community violence exposure.

Mazza and Reynolds (1999) examined the relation of community violence exposure to suicidal ideation, depression, and symptoms of post-traumatic stress disorder within a sample of 94 adolescents from an inner-city school. This sample of sixth,

seventh, and eighth graders was primarily African-American (70%) with a mean age of 12.52 years. In the current study, they found that PTSD symptoms mediated the relation between exposure to violence and depressive symptomatology and suicidal ideation. Mazza and Reynolds (1999) suggest that community violence exposure results in PTSD symptomatology, which then leads to depressive symptomatology and suicidal ideation. They showed that depression and suicidal ideation are indirectly related to violence exposure. This study focused on witnessed community violence exposure and did not include victimization (Mazza & Reynolds, 1999).

Community Violence Exposure, Family Factors, and PTSD Rates

In a study of 70 African-American children 10-15 years old, living in and around an inner-city public housing development, Overstreet and Braun (2000) examined the perceptions of safety and family conflict in relation to community violence exposure and posttraumatic stress disorder. Perceptions of safety are indicated as possible mediators of the relation between exposure to community violence and PTSD based on previous research that suggest that violence undermines youths' basic beliefs that the world is safe, predictable, and controllable and replaces them with a view of the world as a dangerous place (Overstreet & Braun, 2000). Family conflict was examined on the assumption that it would interfere with the availability or effectiveness of support to children from parents and that this diminished social support therefore limits children's opportunities to actively process the trauma. This inability to actively process the trauma with a caregiver would make the child more vulnerable to the development of PTSD (Overstreet & Braun, 2000). Consistent with previous studies, they found a significant relation between

exposure to community violence and the presence of PTSD symptoms. Subsequent analyses revealed that decreased child perceptions of neighborhood safety and increased family conflict mediated the impact of exposure to community violence on PTSD symptoms, resulting in the relation between community violence exposure and PTSD no longer being significant. A weakness of the Overstreet and Braun study was its cross-sectional design, which prevented conclusions about the temporal relations among the variables.

Social constraints, defined as feelings that one cannot safely disclose their fears and concerns regarding distressing events to others (Kliewer, Lepore, Oskin, & Johnson, 1998), have been identified as a predictor of children's adjustment subsequent to community violence exposure (Kliewer et al., 1998; Ozer & Weinstein, 2004). In their study of 99 children between the ages of 8 and 12 living in high-violence, urban neighborhoods, Kliewer and colleagues (1998) examined moderators and mediators of the links between violence exposure and psychological well-being. It was hypothesized that intrusive thinking results from violence exposure, which then leads to increased risk for depressive and anxious symptoms. As discussed earlier, intrusive thoughts about a traumatic event are considered one of the key components of PTSD (APA, 2000). In addition to this mediating link of intrusive thoughts, social constraints were investigated as potential moderators of the relation between violence exposure and intrusive thoughts as well as the association of intrusive thoughts and internalizing symptoms. Within this study, intrusive thoughts mediated the relation between violence exposure (both victimization and witnessing) and internalizing symptoms when controlling for age,

gender, maternal education, and concurrent stressors. Subsequent analyses revealed a moderating effect of social constraint so that children who reported either low levels of maternal support or high levels of social strain were at the highest risk for intrusive thoughts (Kliewer et al., 1998). Results suggest that children's depressive and anxious symptoms can be predicted by their exposure to community violence and their ensuing intrusive thoughts in response to the trauma. However, social supports can moderate this association (Kliewer et al., 1998).

Building on the work of Kliewer et al. (1998), Ozer and Weinstein (2004) studied an ethnically diverse group of 349 seventh grade adolescents from a major metropolitan area in California to identify protective factors for youth who are exposed to community violence. They examined the role of social support, social constraint, and feelings of safety at school on psychological functioning in the context of community violence exposure. Social support measured the students' perceived emotional support (helpfulness) separately for five support providers (mother, father, sibling, friend, and teacher) and social constraint assessed the students' inability to talk about a violent experience with people whom they are close to. Results showed that perceived helpfulness of mothers and fathers moderated the relation between exposure to violence and PTSD symptoms. Specifically, adolescents who rated their mothers or fathers as less helpful reported higher PTSD symptoms as exposure to violence increased, whereas those who rated their parents as more helpful did not exhibit this increase in symptoms. Feelings of school safety were not found to affect levels of PTSD symptomatology, however, adolescents who felt they had to keep feelings about violent events to

themselves reported higher PTSD symptoms. Of the subsample that indicated talking with someone about a violence experience within the last 6 months, 35% reported that the person gave them the idea that they did not want to hear about it and 46% stated that they kept feelings to themselves because it made the other person uncomfortable to hear about it. These findings suggest that youth who feel that they can openly talk about violent events with their parents and who perceive their parents as helpful when they have a problem have a lower risk of developing PTSD following exposure to community violence.

Building on the previous work by Kliewer et al. (1998) and Ozer and Weinstein (2004), Reid-Quiñones and Kliewer (2005) examined the role of social constraints in PTSD symptom changes after additional exposure to community violence among 101 youth between the ages of 9 and 11. Children in the study lived in moderate- to high-violence urban neighborhoods and were primarily (96%) African-American. They were assessed at two time points, approximately six months apart, and reported on PTSD symptomology, frequency of witnessed community violence, felt acceptance from their caregivers, and social constraints. Unlike previous studies of social constraint, the study was longitudinal and therefore was able to control for prior violence exposure and PTSD symptomatology. After controlling for violence exposure, previous PTSD symptoms, and current level of felt acceptance from caregivers, constraints in talking about violence with parents significantly predicted change in youths' PTSD symptoms. Results revealed that youth with higher levels of felt acceptance from caregivers reported lower levels of PTSD symptoms and youth with lower levels of constraint in talking about violence

endorsed fewer symptoms of PTSD. This study reveals that even when parents are supportive of their children, their openness to hearing about violent experiences is a more important factor in youths' psychological adjustment following exposure to community violence.

In a longitudinal study of 86 Palestinian children with a mean age of 14.04 years, who experienced the political violence of the Intifada in 1993, Pumamäki and colleagues (2001) found that discrepant perceived parenting was related to post-Intifada psychological adjustment. Sociopolitical stress moderated the relation of violence exposure and subsequent PTSD symptoms, while perceived parenting style did not. However, results showed that youth who perceived their mothers as highly loving and caring, but their fathers as not so loving or caring reported higher levels of PTSD than other youth. Similarly, children who perceived their fathers as rejecting and hostile and their mothers as nonrejective and nonhostile reported higher levels of PTSD symptoms. The importance of parental relationships as a significant predictor of post-violence adjustment complements the work of Ozer and Weinstein (2004) on social supports and social constraints following community violence exposure. In addition, the Pumamaki study concurred with previous research that found females to be more vulnerable to PTSD than boys. However, the nature of political violence exposure may prevent the findings of the study generalizing to other contexts. Additional research on the impact of parenting styles psychological adjustment should be replicated in the context of community violence.

Recently, Self-Brown and colleagues (2006) examined the relations of community violence exposure, parental mental health, and adolescent PTSD and depression. They obtained data from 121 urban, low-income adolescents and their parents regarding adolescent exposure to violence (i.e. hearing about violence, witnessing violence, and direct victimization), youth PTSD symptoms, and parent self-reported symptoms of depression and PTSD. Sixty-one percent of the youth in the study reported exposure to a traumatic event. Regression analyses revealed that after controlling for demographic variables and family violence exposure, parental mental health moderated the relation of community violence exposure and adolescent-reported PTSD symptoms, but did not explain the relation between adolescent violence exposure and depressive symptoms. Adolescents whose parents reported high levels of PTSD symptoms had more PTSD symptoms as violence exposure increased. This relation did not hold true for youth whose parent reported lower levels of PTSD symptoms. This study confirms previous work that has indicated that those with a family history of psychiatric illness are at an increased risk for PTSD (e.g. Davidson, Hughes, & Blazer, 1991; Davidson, Swartz, Storck, Krishnan, & Hammett, 1985)

In sum, a number of family factors involved in the development of PTSD following community violence exposure have been identified. Familial social support has repeatedly been recognized as a key factor in determining youth outcomes after violence exposure (Kliewer et al., 1998; Ozer & Weinstein, 2004). Additionally, social constraints in talking about violence have been found to be related to PTSD symptomatology (Kliewer et al., 1998; Ozer & Weinstein, 2004; Reid-Quiñones &

Kliewer, 2005). Fitzpatrick and Boldizar (1993) indicated that children raised in homes with few or no stable male figures present were at increased risk for PTSD following victimization while Pumamäki et al. (2001) found that low paternal warmth was predictive of PTSD outcomes.

Numerous studies focus on the negative consequences of community violence on the psychological adjustment of exposed youth; however, only recently have researchers begun to examine the pathways that result in these outcomes (See Table 1 for a summary of these studies). Furthermore, posttraumatic stress disorder is the most commonly cited internalizing problem associated with community violence exposure and only a handful of studies have attempted to explain the factors that contribute to this deleterious relationship. These studies point to a number of family-oriented variables as contributors of PTSD symptomatology. It is clear from the lack of published studies that additional work is required in this area.

Although there is a dearth of work explicating moderators or mediators of the links between exposure to community violence and PTSD symptoms, there are several theoretical models that can guide work in this area. Cicchetti and Lynch (1993) proposed an ecological-transactional model of exposure to community violence based on the earlier work of Bronfenbrenner (1989). In this model, they assert that exposure to community violence affects child adaptation through its influence on the multiple contexts surrounding the child. It is disturbances within the child, as well as within the family that absent of compensatory factors, community violence can have negative effects on the child's adaptation. This results in an increased vulnerability to mental health problems

Table 1 (Continued)

Author(s)	Study Goals	Population Characteristics	Type of Violence	Study Design	Measures	Results
Paxton, Robinson, Shah, & Schoeny (2004)	Examine the relation of CVE to depressive & PTSD symptoms in a sample of low-income African American male adolescents	77 ninth grade African-American males; 13-16 yrs; 82% endorsed one or more indicators of poverty	Hearing, witnessing, & victimization	Cross-sectional	Screening Survey of Exposure to Community Violence; Social Support Rating Scale; Center for Epidemiological Studies-Depression Scale; Checklist of Post-Traumatic Stress Symptoms	74% had seen someone get shot or shot at with a gun and 30% had themselves been shot at with a gun. CVE was associated with both depressive & PTSD symptoms. Social support did not moderate the relation between CVE and psychological distress.
Reid-Quiñones & Kliewer (2005)	Examine the relation of social constraints to PTSD symptoms in the context of CVE	69 urban youth; 9-11 yrs; 96% African-American	Witnessing	Longitudinal	Frederick's PTSD Reaction Index; Survey of Exposure to Community Violence; Children's Report of Parent Behavior Inventory; Social constraints measure	After controlling for Time 1 PTSD symptoms, witnessed violence at Time 1, and level of felt acceptance from parent, Time 2 witnessed violence and constraints in talking about violence with parents significantly predicted change in PTSD symptoms.
Self-Brown, LeBlanc, Kelley, Hanson, Laslie, & Wingate (2006)	Examine the relations of CVE, parental mental health, and adolescent PTSD and depression.	121 adolescents and their parents; 13-16 yrs; 50% male, 50% female	Hearing, witnessing, & victimization	Cross-sectional	Screen for Adolescent Violence Exposure; Trauma Symptom Checklist for Children; Symptom Checklist-90-Revised; Posttraumatic Stress Diagnostic Scale	After controlling for demographic variables and family violence exposure, parental mental health emerged as a moderating variable in the relation between CVE and adolescent-rated PTSD, but not in the association between adolescent CVE and depression.

Table 1 (Continued)

Author(s)	Study Goals	Population Characteristics	Type of Violence	Study Design	Measures	Results
Overstreet & Braun (2000)	Examine perceptions of safety & family conflict in relation to ECV & PTSD	70 inner-city, African-American youth 32 males, 38 females; Ages 10-15	Hearing, witnessing, & victimization	Cross-sectional	Exposure to Community Violence, Checklist of Children's Distress Symptoms, Life Events Checklist, Perceptions of Safety, Family Conflict subscale of FES	Significant relation of ECV & PTSD. Decreased child perceptions of neighborhood safety & increased family conflict mediated the impact of ECV—making the relation of ECV & PTSD no longer significant.
Overstreet, Dempsey, Graham, & Moely (1999)	Determine if the availability of family support moderates the impact of CVE on internalizing symptoms.	75 low-income African-American males & females, ages 10-15, recruited from a federally funded summer program for 5^{th}-8^{th} graders in a local housing development	Hearing, witnessing, & victimization	Cross-sectional	Things I Have Seen and Heard; Checklist of Children's Distress Symptoms; Children's Depression Inventory; Life Events Checklist	92% heard gun fire in neighborhood; 83% knew someone killed by violence; 55% witnessed a shooting; 43% seen a dead body in neighborhood; & 37% victim of physical violence. 33% of sample displayed a symptom pattern consistent with PTSD; CVE predicted PTSD symptoms. Availability of family support & family size did not moderate the relation between CVE & PTSD, but did explain the relation between CVE and depression.
Ozer & Weinstein (2004)	Examine recent ECV, protective factors, & current psych. functioning	349 7^{th} graders, metro CA, 39% Asian, 28% Hispanic, 21% Af-Am, 5% Cau; 52% male, 48% female;	Witnessing & Victimization	Cross-sectional	Children's Report of Exposure to Community Violence; daily hassles, social support, school safety; Trauma Symptom Checklist for Children	Greater exposure resulted in higher levels of PTSD symptoms. Parental support & lower perceived constraints emerged as protective factors in relation of ECV & PTSD.

(Table continues)

Table 1 (Continued)

Author(s)	Study Goals	Population Characteristics	Type of Violence	Study Design	Measures	Results
Kilpatrick, Ruggiero, Aceirno, Saunders, Resnick, & Best (2003)	Provide prevalence, comorbidity, & risk-factor data for PTSD, major depressive disorder, & substance abuse	4,023 National Survey of Adolescents; 12-17 yrs; representative sample of adolescents	Sexual & physical assault, witnessed violence	Cross-sectional	Modified version of the National Women's Study (NWS) PTSD Module	Ethnicity (Hispanic or Af-Am) & older age sign associated w/ PTSD. Comorbid PTSD & MDE: female, History of familial drug use problems, witnessed violence, sexual assault, & physical assault all increased risk.
Kliewer, Lepore, Oskin, & Johnson (1998)	Examine social support & social strain as mediators of intrusive thoughts after VE	99 "mom" & child dyads; 40 boys, 59 girls; 8-12 yrs; 96% African-American	Hearing, witnessing, & victimization	Cross-sectional	Survey of Exposure to Community Violence; Children's Impact of Traumatic Events Scale – Revised; Child Behavior Checklist; Children's Depression Inventory; RCMAS	Depression & anxiety symptoms predicted by ECV & intrusive thoughts. Social Support from moms moderated intrusive thoughts. Social strain a more critical moderator.
Lipschitz, Rasmusson, Anyan, Cromwell, & Southwick (2000)	Identify clinical and functional correlates of PTSD in trauma-exposed urban adolescent girls	90 females attending routine medical appointments at a hospital-based, adolescent primary care clinic, ages 12.8 to 20.8 years	Hearing, witnessing, victimization, & perpetration	Cross-sectional	Child Exposure to Violence Checklist; Childhood Trauma Questionnaire; Child PTSD Checklist; a subset of girls were interviewed with the K-SADS-PL	86% reported witnessing community violence, 68% heard about a homicide, and 4.5% had been shot or stabbed. 15% met criteria for PTSD and 12% met criteria for partial PTSD. Females with PTSD were significantly more depressed, had increased rates of cigarette and marijuana use, reported poorer school performance.
Mazza & Reynolds (1999)	Examine the relation of CVE to suicidal ideation, depression, and PTSD symptomatology	94 urban adolescents; 11-15 yrs; 61% female, 39% male; 70% African-American, 22% Latino, 1% Native American, 1% Caucasian, 3% other	Hearing & witnessing	Cross-sectional	Reynolds Adolescent Depression Scale; Suicidal Ideation Questionnaire-Junior; Exposure to Violence Questionnaire; Adolescent Psychopathology Scale-PTSD subscale	93% of youth reported past year violence exposure. The relation between CVE and PTSD was significant controlling for depression & suicidal ideation severity. PTSD functioned as a mediator in the relation between CVE and depression and suicidal ideation.

(Table continues)

Table 1 (Continued)

Author(s)	Study Goals	Population Characteristics	Type of Violence	Study Design	Measures	Results
Fehon, Grilo, & Lipschitz (2001)	Examine correlates of ECV in psychiatrically hospitalized adolescents	89 adolescents; 12-18 yrs; 57% female, 43% male, 72% Caucasian, 16% Latino, 12% African-American	Witnessing, victimization, & perpetration	Cross-sectional	Children's Exposure to Violence Checklist; Childhood Trauma Questionnaire; Child Posttraumatic Stress Checklist; Adolescent Dissociative	Inpatients exposed to CV reported significantly higher PTSD Sx, drug-related problems, & greater violence potential than patients not exposed to community violence.
Fitzpatrick & Boldizar (1993)	Examine the relation between CVE & PTSD in a sample of low-income African American youth	221 adolescents; 7-18 yrs; 46% male, 54% female	Witnessing & victimization	Cross-sectional	Survey of Exposure to Community Violence; revised version of the Purdue Post-Traumatic Stress Scale	Victimization and witnessing violence associated with PTSD symptoms. Symptoms were higher for victimized females and youth who had no primary males living with them in the household.
Horowitz, McKay, & Marshall (2005)	To understand the impact of community-level stressors, coping strategies, & resources to prevent exposure to violence or to mitigate its effects in an inner-city community through the use of parent & child focus groups and child-completed standardized measures.	28 child participants; 8-17 yrs; 43% African American, 29% Latino, 27% mixed ethnicity	Hearing, witnessing, & victimization	Cross-sectional	UCLA PTSD Index; Focus groups with parents and children (separately)	61% of children reported hearing about violence, 50% reported witnessing violence, & 46% reported direct victimization. 50% of youth met criteria for PTSD and 21% met criteria for partial PTSD.
Horowitz, Weine, & Jekel (1995)	Describe the assessments for CVE and PTSD symptoms in a sample of urban adolescent females	79 urban female adolescents; 12-21 yrs; 81% African-American, 15% Latino, 3% Caucasian, attending an adolescent medicine clinic	Hearing, witnessing, victimization, & perpetration	Cross-sectional	Adolescent Self-Report Trauma Questionnaire	67% met criteria for PTSD; increased number of types of violent events was positively associated with meeting PTSD criteria and with increased PTSD severity scores.

(Table continues)

Table 1

Studies Examining the Relation of Community Violence Exposure and PTSD

Author(s)	Study Goals	Population Characteristics	Type of Violence	Study Design	Measures	Results
Berman, Kurtines, Silverman, & Serafini (1996)	Assess the amount & severity CVE and crime in an urban sample of adolescents	96 adolescents; 14-18 yrs;	Witnessing & victimization	Cross-sectional	Survey of Exposure to Community Violence; PTSD Reaction Index; Analysis of Social Support in School Transitions;	93% reported witnessing a violent event; 44% reported direct victimization; 35% met diagnostic criteria for PTSD. Perceived social support was a more effective predictor of positive outcome than social support actually received.
Berthold (1999)	Examine the relation between violence exposure & mental health outcomes among Khmer refugee adolescents.	76 Khmer adolescents; 11-19 yrs	Witnessing & victimization	Cross-sectional	Survey of Children's Exposure to Community Violence; Columbia Impairment Scale; LA PTSD Index	1/2 of adolescents directly experienced violence; 2/3 witnessed violence; 25% partially or fully met diagnostic criteria for PTSD. The number of violent events exposed to in their lifetime significantly predicted level of functioning and PTSD.
Berton & Stabb (1996)	Examine variables associated with the incidence of PTSD symptoms in urban adolescents.	97 high school juniors; 22% male, 78% female; 47% African-American, 53% Caucasian	Witnessing	Cross-sectional	Keane PTSD Scale; The Civilian Mississippi Scale for PTSD	Exposure to domestic or community violence was the only variable examined found to be associated with and predictive of PTSD. African-American males were exposed more violent crimes than Caucasian males.
Dempsey, Overstreet, & Moely (2000)	Examine the moderating role of coping in the relation between CVE and PTSD symptoms in urban youth.	70 adolescents; 11-14 yrs; 51% male, 49% female, 100% African-American	Hearing, witnessing, & victimization	Cross-sectional	Things I Have Seen and Heard (Richters & Martinez, 1990); KidCope (Spirito et al., 1988); Checklist of Children's Distress Symptoms (Richters & Martinez, 1990)	Cognitive distraction moderated the level of violence exposure; as violence exposure increased, the use of avoidance coping was related to increased frequency of cognitive & behavioral arousal. Approach coping did not moderate the relation between CVE and PTSD.

(Table continues)

such as PTSD. The disturbances are theorized to represent the mechanisms through which community violence leads to negative developmental outcomes (i.e. PTSD).

Familial Substance Use and PTSD

The present study addresses this gap in the literature by examining one factor, maternal drug and alcohol abuse, that may explain why some youth exposed to community violence develop symptom of PTSD while others do not. Family moderators of links between community violence exposure and PTSD symptoms in youth are particularly important to examine because the family is an important microsystem for the child, and children exposed to community violence often turn to members of the family for guidance and support.

Maternal alcohol and drug abuse is an important factor to examine as a potential moderator of PTSD symptoms in youth exposed to community violence due to the high rates of children exposed to parental substance abuse. A recent epidemiological study estimated that one in four children in the United States is exposed to a family member's alcohol abuse or dependence (Grant, 2000). Additionally, nearly ten percent of children in the United States live in homes where at least one parent has used illicit drugs in the past month with marijuana being the most frequent (National Institute of Drug Abuse, 1994).

Familial Substance Use and Child Outcomes

Researchers consistently have found negative outcomes for children exposed to parental substance use, including both behavioral and emotional difficulties for offspring of drug abusers. Researchers have identified the following behavioral and emotional

problems for children in families with alcohol and illicit drug abusing parents: running away (McGaha & Leoni, 1995), impaired emotional functioning such as low self-esteem (West & Prinz, 1987); poorer academic achievement and school problems (Sher, 1991, Sher, Walitzer, Wood, & Brent, 1991); and conduct problems such as physical aggression, lying, stealing, and truancy (Reich, Earls, Frankel, & Shayka, 1993). In addition, these children experience higher levels of depression and anxiety, as well as increased use of mental health services, and a greater incidence of psychopathology (Chassin, Rogosch, & Barrera, 1991; Dobkin, Tremblay, Desmarais-Gervais, & Depelteau, 1994; Lynskey, Fergusson, & Horwood, 1994). Parental substance abuse also places children at an increased risk for abuse of alcohol and other drugs (Child Welfare League of America, 2001; Widom, 2000) in addition to physical abuse, sexual abuse, and neglect (Child Welfare League of America, 2001).

Children of substance-abusing parents experience higher rates of internalizing disorders and symptomatology than children in the general population. Nunes and colleagues (2000) reported that 21% of children (ages 6 - 17) of opiate dependent parents indicated a lifetime prevalence of a mood disorder and 24% experienced an anxiety disorder. A report of Surgeon General (U.S. Department of Health and Human Services, 1999) indicated that the prevalence rates for mood disorders and anxiety disorders as 6.2% and 13%, respectively, in an epidemiological study of mental heath in children ages 9 to 17. These considerably higher rates of internalizing disorders in youth of substance-abusing parents clearly identify children of drug abusers as a high-risk group for mental health problems.

Children are at a higher risk for developing mental health problems when the substance-abusing parent is female. Nunes et al. (2000) reported that children of female opiate addicts were at higher risk for childhood anxiety disorders than children of male addicts. This study expands on previous research that revealed that children with a maternal history of alcoholism displayed more psychiatric diagnoses, including internalizing disorders, than did controls (Hill & Muka, 1996). The stronger association of maternal substance abuse on child outcomes over paternal substance abuse can be explained by the fact that mothers are more often the primary caregivers for their children.

Additionally, researchers have found that maternal substance abuse problems frequently co-occur with mental health problems (Hesselbrock, Meyer, & Kumes, 1985; Luthar, Cushing, Merikangas, & Rounsaville, 1998; VanDeMark, Russell, O'Keefe, Finkelstein, Noether, & Gampel, 2005). Luthar et al (1998) reported that among a sample of 119 cocaine and opioid abusing mothers, 89.7% had at least one affective or anxiety disorder; 60% had comorbid alcoholism, and nearly 30% had diagnoses of Antisocial Personality Disorder. Furthermore, this comorbidity is often complicated with family exposure to trauma and violence (Amaro, Fried, Cabral, & Zuckerman, 1990; Gropper, 1985).

The crucial position of mothers as the typical primary caregiver places children at higher risk for experiencing a more stressful and less nurturing home environment that results from their mother's poor psychological health. Children of women experiencing substance abuse, mental illness, and violence are more likely to be exposed to

inconsistent, unresponsive, and ineffective parenting as well as family violence, child abuse, and neglect than children who are not exposed to such parental impairment (Egeland & Susman-Stillman, 1996; Juades, Ekwo, & Van Voorhis, 1995; Stevens & Arbiter, 1995).

Parental substance abuse is related to a number of negative parenting behaviors. Smith (2004) examined the differences in maternal discipline use based on maternal substance use, maternal depression, social support, and socioeconomic variables in a nationally representative sample of families investigated by child protective services for maltreatment. He found that substance dependent mothers were more likely to use all types of physical, emotional aggression and neglectful behaviors than non-substance dependent mothers. Mothers with less severe substance use problems were also examined and it was found that they also were more likely to abuse and neglect their children than mothers without such problems.

Studies have also linked parental substance use with deficient parenting including poor monitoring, decreased social support (Chassin, Curran, Hussong, & Colder, 1996; Curran & Chassin, 1996), and disciplining their children in a lax or coercive manner (Vaillant & Milofsky, 1982). Locke and Newcomb (2004) found that parental drug problems, in concert with childhood maltreatment, had an adverse impact on parenting practices among mothers, but not fathers. Parenting practices related to such problems were decreased warmth, increased aggression, undifferentiated rejection, and indifferent neglect. Furthermore, there is also an increased risk of physical abuse in families with substance abusing parents. Miller, Maguin, and Downs (1997) found that parents who

have a lifetime history of alcohol problems are more likely to use harsh physical punishment with their children. Additionally, cross-sectional and longitudinal data from the Epidemiological Catchment Area (ECA) suggest that children with substance abusing parents are more likely than children in families without substance abuse to experience physical abuse (Chaffin, Kelleher, & Hollenberg, 1996).

Familial Substance Use and Violence Exposure

In addition, a number of studies have indicated that familial substance use increases the risk for exposure to violence. Hanson, Self-Brown, Fricker-Elhai, Kilpatrick, Saunders, and Resnick (2006a) studied the relations among family environment and violence exposure. Violence exposure was defined as witnessing violence in their home or community, physically abusive punishment by a caregiver, physical assault by a noncaregiver, and unwanted sexual contact. Results revealed that family substance use and not always living with a natural parent were significantly associated with all three types of violence exposure (witnessing violence, physical assault, and sexual assault). This suggests that children of drug abusers face greater opportunities for exposure to violence, violence in the home as well as violence in the community.

Familial Substance Abuse and PTSD

There is also some research to support genetic links between substance abuse and PTSD. In a study examining the rates of PTSD in drug-abusing probands and their relatives, Dierker and Merikangas (2001) found that while relatives of drug-abusing probands are no more likely to experience a traumatic event, they are more vulnerable to

developing PTSD after such exposure than are those not related to drug-abusing probands. This study corroborated previous studies that found an increased risk for PTSD among individuals with a family history of psychiatric disorders (Davidson, Hughes, & Blazer, 1991; Davidson, Swartz, Storck, Krishnan, & Hammett, 1985) and also expanded on those findings to suggest that illicit drug use disorders represent a strong familial association

Purpose and Proposal

The purpose of this study was to better understand the relationship between community violence exposure and PTSD symptomatology in youth. Numerous researchers have identified PTSD as a consequence of community violence exposure. However, not all children who experience community violence will exhibit symptomatology of PTSD. Few factors have been isolated to describe why some youth are more likely than others to develop PTSD symptoms following violence exposure. Studies have noted a range of parental mental health problems that are associated with the development of PTSD in children; however, parental history of substance abuse has not been widely discussed. Additionally, studies examining the relation of parental substance abuse and later youth internalizing problems have focused on depression, overanxious disorder, separation anxiety disorder, and common phobias with little study of the specific relation on parental substance abuse to child PTSD symptomatology.

It was hypothesized that violence exposure and PTSD symptomatology would be positively correlated. It also was expected that the association between violence exposure and PTSD symptoms would be stronger for girls than boys, and girls were expected to have higher levels of PTSD symptoms than boys. This relation was expected due to previous work that has found PTSD is more common in females than males exposed to a traumatic event. Additionally it was predicted that a positive history of maternal substance abuse would be related to higher PTSD symptoms levels compared with no history of maternal substance abuse. Furthermore, maternal substance abuse history was hypothesized to moderate the relation between violence exposure and

subsequent PTSD symptom levels. Children who are exposed to community violence and whose maternal caregiver has abused alcohol or drugs were expected to report higher levels of PTSD symptoms than children who are exposed to community violence and whose maternal caregiver has not abused alcohol or drugs. It was also hypothesized that deficient parenting and poorer psychological functioning of the substance-abusing caregiver would explain the relation of maternal substance abuse to community violence exposure and PTSD.

Methods

Participants

The current study was part of a larger study on community violence and substance use in urban adolescents. Participants in the larger study included 362 mother/female-caregiver and youth dyads recruited from high-violence areas of Richmond, Virginia. The sample for the current study was restricted to biological mothers and their 5th (54%) or 8th (46%) grade children (N = 309 dyads). Youth were primarily African-American (91%) with a mean age of 12.08 years old (*SD* = 1.60, range from 9-16) and over half (52%) of were female. A two-cohort design was used in order to track students as they transitioned into middle and into high school. Biological mothers were primarily African-American with a mean age of 36.70 (*SD* = 6.35, range from 24-56). The families typically consisted of three children (*M* = 2.8, *SD* = 1.45) and two adults (*M* = 1.8, *SD* = 0.81) with 50 percent of the families living on a household income of less than $20,000 per year.

Measures

Demographics. Youth and their maternal caregiver were asked to report on the youth's age, grade, gender, and race (See Table 2). Additionally, the maternal caregiver reported her age, relationship to the child, current marital status, race, education level, current employment status, family income (See Table 3).

Survey of Children's Exposure to Violence. Youth exposure to community violence was assessed using the Survey of Children's Exposure to Violence (Richters &

Table 2

Demographic Characteristics of Children (N = 309)

Characteristic	*n*	%
Grade level at time of interview		
5th grade	168	54.4
8th grade	141	45.6
Gender		
Female	162	52.4
Male	147	47.6
Race		
African American	279	90.6
Caucasian	12	3.9
Asian American	2	0.6
Hispanic/Latino	0	0
American Indian	7	2.3
Other	8	2.6
Missing	1	< 0.1

Table 3

Demographic Characteristics of Biological Mothers (N = 309)

Characteristic	*n*	%
Race		
African American	281	90.9
Caucasian	18	5.8
Asian American	1	0.3
Hispanic/Latina	1	0.3
American Indian	1	0.3
Other	6	1.9
Multiracial	1	0.3
Marital status at time of interview		
Never married	130	42.1
Married	76	24.6
Living together	21	6.8
Separated	48	15.5
Divorced	30	9.7
Widowed	3	1.0
Missing	1	0.3

(Table Continues)

Table 3 (Continued)

Characteristic	*n*	%
Highest Education Level Completed		
No diploma	69	22.3
GED	23	7.4
High school diploma	74	23.9
Some college, no degree	70	22.7
Vocational degree	22	7.1
Associate's degree	18	5.8
Bachelor's degree	26	8.4
Master's degree	3	1.0
Advanced degree	2	0.6
Missing	2	0.6
Employment status at time of interview		
Full time	145	46.9
Part-time	43	13.9
Homemaker/caregiver	40	12.9
Unemployed	41	13.3
Unable to work	21	6.8

(Table Continues)

Table 3 (Continued)

Characteristic	*n*	%
Employment status at time of interview (Continued)		
Student	6	1.9
Student and employed	12	3.9
Retired	1	0.3
Household earnings per week ($)		
< 100	21	6.8
101-200	25	8.1
201-300	53	17.2
301-400	50	16.2
401-500	35	11.3
501-600	32	10.4
601-700	26	8.4
701-800	16	5.2
801-900	12	3.9
901+	35	11.5
Missing	4	1.3

Saltzman, 1990). This 47-item measure assesses the frequency a child has been victimized by, witnessed, or heard about 20 different forms of violence and violence-related activities within their community. Respondents indicate on a scale from 0 (*never*) to 4 (*almost every day*) how often they had been victimized (10 items), witnessed violence (21 items), or heard about violence (16 items) in the past year as well as in their lifetime. A sample victimization item is "How many times have you been chased by gangs or older kids?" A sample witnessing item is "How many times have you seen someone attacked or stabbed with a knife?" Hearing about items included "How many times have you only heard about someone being shot in your community?" This measure has been used in many studies including the National Institute of Mental Health Community Violence Project conducted by Richters and Martinez (1993). Lifetime frequency of experiencing and seeing violence was assessed in this study, with higher values reflecting more exposure. Lifetime rates, rather than past year exposure rates, were used in the current study because only using past year violence exposures rates would not accurately reflect the total traumas experienced by the child that may contribute to PTSD symptoms. Reliability analyses revealed an internal consistency alpha coefficient of .60 for the lifetime victimization subscale and .78 for the lifetime witnessed violence subscale.

Trauma Symptom Checklist for Children (TCCS). Youth's symptoms of posttraumatic stress disorder was measured with the TCCS (Briere, 1996). The TCCS is a 54-item scale developed to evaluate symptoms of PTSD in children who have experienced a traumatic event. It consists of two validity scales (Underresponse and

Hyperresponse) and six clinical scales (Anxiety, Depression, Anger, Posttraumatic Stress, Dissociation, and Sexual Concerns). The Posttraumatic Stress scale, which includes 10 items, was used in the current study. Each item is rated on a 4-point scale with 0 indicating "never" and 3 indicating "almost all of the time." Reliability analyses in the normative sample yielded high internal consistency for Posttraumatic Stress scale with an alpha of .87. Reliability analyses of the current sample produced an internal consistency alpha coefficient of .85. According to Briere and Elliott (1997), various studies using the TSCC indicate that it has convergent and predictive validity in samples of traumatized and nontraumatized children.

Family Alcohol and Drug Survey (FADS). Maternal drug and alcohol use was measured using the FADS. The FADS is a semistructured research interview that employs a family genogram to gather information on family history of alcohol and drug use in first- and second-degree relatives using the Family History-Research Diagnostic Criteria (FH-RDC; Andreasen, Endicott, Spitzer, & Winokur, 1977). It was originally created to acquire data on alcohol, drug use, and mental disorders of patients and their relatives in several research projects (Svikis, McCaul, Haug, & Boney, 1996). The FADS distinguishes five alcohol/drug patterns ranging from heavy problematic substance use to abstinence (See Tables 4 & 5). The maternal caregiver is asked to classify the drug and alcohol use patterns of the youth's maternal and paternal family members. Interrater reliability for FH-RDC diagnosis of alcoholism is very high (0.96) (Andreasen, et al., 1977). Staff training in the administration and interpretation of the FADS requires 6-8 hours, which typically included staff observing two interviews and completing one

independent interview that was tape-recorded and then approved before completion of an official interview. The FADS interview can be completed in approximately 20-30 minutes.

Type A alcohol use by the child's biological father was reported by 19% of mothers, while 15% reported Type B alcohol use. Thirty-one percent of mothers reported that the biological father used alcohol socially (Type C) with another 18% reporting that the father rarely drank and never become intoxicated when drinking (Type D). Thirteen percent of mother's reported that the father never completed a full drink of alcohol (Type E) while 3% did not know the father's alcohol use patterns.

Type A drug use by the biological father was reported by 20% of mothers with an additional 10% reporting Type B drug use by the father. Fifteen percent of mothers indicated Type C drug use by the father and 17% reported Type D use. Thirty-five percent of mothers classified the child's father as a Type E for drug use, while 3% did not know the father's drug use patterns.

Child Report of Parent Behavior Inventory (CRPBI). Quality of the maternal caregiver-child relationship was measured using the CRPBI, a 108-item developed to measure how much a child feels accepted by his/her maternal caregiver; an important protective factor. The 20-item Acceptance/Rejection subscale from the Child Report of Parent Behavior Inventory (Schaefer, 1965) was used in the current study. Using a 3-point Likert scale, children rated the extent to which they felt the statements were representative of their mother, from 1 (*like my parent*) to 3 (*not like my parent*). Sample items included "understands your problems and your worries" and "enjoys doing things

with you." Research by Kliewer and Kung (1998) suggests that the Child Report of Parent Behavior Inventory has good internal consistency (αs > .90), and predicts children's adjustment problems. In this study, Cronbach alpha reliability was .87. Higher scores indicate greater felt acceptance.

Network of Relationships Inventory – Revised (NRI-R). The NRI-R was used to assess youth's quality of relationship with their maternal caregiver, father/male figure, and another adult that they identified as feeling close to. The full NRI consists of 80 items as it assesses the quality of eight relationships experienced by the respondent. For the current study, seven items that assess support and one item that assesses conflict were employed to measure the qualities of respondents' relationships with mothers. The respondents indicated on a standard 5-point Likert scale how strongly each attribute was experienced in the relationship (from 1 = "little or none" to 5 = "the most possible"). The internal consistency of the complete NRI in previous samples is good (mean alpha = .80) (Furman & Buhrmester, 1985). The current study yielded high internal consistency (Cronbach alpha = .86) for the shortened version of the NRI.

Parenting Practices Scale. The Parenting Practices Scale (Kerr & Stattin, 2000) was used to measure youth's views of parents' knowledge, disclosure to parents, solicitation, and control. Maternal caregivers answered the same questions, only with minor changes in wording when necessary. The scale consists of 24 items that are rated on a 5-point scale where 1 indicates higher knowledge and 5 signifies little knowledge. Most items are reverse scored so that the higher the score, the higher the knowledge. For the current sample, alpha reliabilities of the parental knowledge subscale were .81 for

Table 4

Biological mother's FADS Type for Alcohol Use

FADS Type	Description of Type	Frequency	Percentage
A	Drank *heavily*, *often* becoming intoxicated when drinking, AND had significant problems caused by drinking (i.e. family, social, job or school, financial, legal, or health problem, or treatment for alcohol abuse).	13	4.3
B	Drank *heavily*, *often* becoming intoxicated when drinking, but did NOT have significant problems caused by drinking	11	3.6
C	Drank *regularly*, *normally* did not become intoxicated when drinking, and did NOT have significant problems caused by drinking (social drinking)	69	22.6
D	Drank *rarely*, *never* became intoxicated when drinking, and did NOT have significant problems caused by drinking (for example, a drink at holidays, weddings, or special occasions)	131	43.0
E	*Never* drank alcohol (or never completed a full drink of alcohol)	81	26.6

Table 5

Biological mother's FADS Type for Drug Use

FADS Type	Description of Type	Frequency	Percentage
A	Used *heavily* AND had significant problems caused by drug use (i.e. family, social, job or school, financial, legal, or health problem, or treatment for drug abuse).	20	6.6
B	Used *heavily* but did NOT have significant problems caused by drug use	5	1.6
C	Used *regularly* and did NOT have significant problems caused by drug use (social or recreational use)	19	6.3
D	Used *rarely* and did NOT have significant problems caused by drug use (experimental use)	66	21.7
E	*Never* used illicit drugs	194	63.8

children's report and .78 for maternal caregiver's report. The child disclosure subscale yielded alpha reliabilities of .77 for children's report and .73 for maternal caregiver's report. Alpha reliabilities were .75 and .66 for youth-reported and maternal caregiver-reported parental solicitation, respectively. For parental control, the alpha reliabilities were .74 and .59 for youths' reports and mothers' report, respectively. Kerr and Stattin (2000) examined the test-retest reliabilities of the four scales after two months with substantial results. The test-retest reliability for child-reported knowledge was high, $r(36) = .83$. The test-retest correlation for child-reported disclosure was .70 ($df = 36$). Child-reported solicitation was highly reliable according to test-retest correlations, $r(36)=.84$. The test-retest reliability for child-reported parental control was high, $r(36)=.82$.

Brief Symptom Inventory. Mothers reported on their own current symptoms distress using the Brief Symptoms Inventory (BSI; Derogatis, 1983). The BSI was developed to evaluate current psychological symptom distress and is oriented toward psychiatric diagnosis. A brief form of the Symptom Checklist (SCL-90-R), it produces scores on nine symptoms dimensions (somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism) and three global indices of distress (global severity index, positive symptom index, and positive symptom total). The current study employs four of the nine dimensions of the BSI: somatization, depression, anxiety and hostility. Reliability analyses of the subscales in the current sample produced internal consistency alpha

coefficients ranging from .76 to .87. Examination of test-retest reliabilities of the BSI subscales resulted in reliabilities ranging from .68 to .91 (Morlan & Tan, 1998).

Life Stresses Scale. The Life Stresses Scale was used as a measure of life stress experienced by mothers. The questionnaire was adapted from a measure designed and used by the Fast Track Project (Conduct Problems Prevention Research Group, 1998). It consists of 20 items assessing specific life stressors that the mother may have experienced in the past six months. Fourteen of these items were based on the measure developed by the Conduct Problems Prevention Research Group and the remaining 6 items were originally developed for use in the Multisite Violence Prevention Project (Miller-Johnson, Sullivan, Simon, & the Multisite Violence Prevention Project, 2004) to reflect the concerns of an urban sample. For each life stressor, mothers indicated whether each of the item "0 = *did not occur,*" "*1 = caused minor stress,*" or "*2 = caused major stress.*" From these responses, a composite score indicating that average severity of stressors experienced by mothers was computed with a higher score reflecting a higher level of life stress. Reliability analyses of the current sample produced an internal consistency alpha coefficient of .75.

Toronto Alexithymia Scale-20. The Toronto Alexithymia Scale-20 (TAS-20; Bagby, Parker, Taylor, 1994), a 20-item measure was administered to the maternal caregiver to assess their comfort with emotion. An assessment of parents' comfort with emotion is an important feature for understanding how parents socialize their children to cope with violence. The TAS-20 asks respondents to rate their agreement with a series of statements on a 5-point Likert scale ranging from 1 (*strongly disagree*) to 5 (*strongly*

agree). Test-rest reliability was examined and resulted in an alpha coefficient of .77 (Bagby et al., 1994). Examination of convergent validity resulted in an alpha coefficient of .84 (Cusack, Deane, Wilson, & Ciarrochi, 2006). For the current sample, alpha reliability of the difficulty identifying feelings subscale was .86. The difficulty describing feelings subscale yielded an alpha reliability of .72 and the alpha reliability was .45 for the externally oriented thinking subscale.

COPE. The COPE (Carver, Scheier, & Weintraub, 1989), a 60-item multidimensional coping inventory designed to assess the different ways in which people usually cope with stress, was used to assess how maternal caregivers cope with violence. The current study used a revised set of directions to instruct respondents to answer the questions in reference to how they cope with violence. The COPE assesses a broad range of coping responses and includes both adaptive and maladaptive responses. Respondents are asked to indicate how much or how frequently they engage in a certain behavior to cope with stress on a 4-point Likert scale from 1 (*I don't do this at all*) to 4 (*I do this a lot*). The COPE consists of three main groupings with five scales per group and four items per scale: problem-focused coping (active coping, planning, restraint coping, seeking social support for instrumental reasons, and suppression of competing activities); emotion-focused coping (positive reinterpretation and growth, religion, humor, acceptance, and seeking social support for emotional reasons); and dysfunctional coping (focus on and venting of emotions, denial, behavioral disengagement, mental disengagement, and alcohol/drug use). The current study used the following scales resulting in 44 items: active coping, planning, seeking social support for instrumental

reasons, seeking social support for emotional reasons, positive reinterpretation and growth, turning to religion, focus on and venting of emotions, denial, behavioral disengagement, mental disengagement, and alcohol-drug disengagement. The alpha reliabilities of the COPE subscales in the current study were all above .70 except for the behavioral disengagement scale (.63) and the mental disengagement scale (.52). Carver et al. (1989) reported that, with a few exceptions, the internal validity of the individual COPE scales do not show excessive intercorrelation.

Procedure

The current study was part of a larger study on the costs of community violence and substance use in an urban setting. Participants were recruited from moderate to high violence areas within the City of Richmond, Virginia. Families were recruited through community agencies and events, by canvassing qualifying neighborhoods via flyers posted door-to-door, and participant referral. To be eligible, participants had to be the female legal guardian of at least one child in the 5th or 8th grade. Eligible families were scheduled for interviews, which were conducted at their home. When requested, interviews were conducted at an alternative location, such as a local community center or an office at Virginia Commonwealth University.

Youth and their maternal caregivers completed separate home interviews lasting 2-3 hours. Before the interviews commenced, trained research assistants reviewed the consent and assent forms with the child and their maternal caregiver and answered any questions. After providing written consent and assent, the caregiver and child were taken to separate rooms where they were interviewed privately by research assistants.

Interviews were conducted face-to-face using visual aids and, for the caregiver, all questions were read aloud. A portion of the child interview was presented to the child in a booklet and completed independently unless the child had difficulty reading. The remaining portion of the interview was conducted with the research assistant reading the questions aloud. Participating families received a total of $50 in Wal-Mart gift cards (caregiver received $45 and child received $5). In addition, families who returned monthly address updates via supplied postcards were entered in a monthly drawing for a $25 Wal-Mart gift card.

Research assistants completed extensive training before being approved to interview families. In addition to face-to-face training with the Research Coordinator and Principal Investigator, interviewers completed the Collaborative Investigator Training Initiative (CITI). Interviewers were provided with ongoing supervision to maintain adherence to training standards. Additionally, a supervisor completed quality control calls to ten percent of the interviewed families to further ensure that interviewers maintained professional standards.

Data Analysis

Preliminary analyses were conducted to produce means, standard deviations, and frequency distributions. Descriptive analyses include Pearson product-moment correlations, which determined the correlations of continuous independent variables, and chi square analyses, which examined differences in categorical independent variables.

Hierarchical regression analyses were performed to understand the direct effects of maternal substance abuse and community violence exposure on youth's PTSD

symptomatology. The hierarchical regressions also allowed for the testing of the hypothesized moderating effect of maternal substance abuse in the predicted relation between exposure to violence and PTSD symptomatology. Youth grade and gender as well as fathers' FADS types were included as control variables in the analyses. For the current analyses, community violence exposure was defined as direct victimization and witnessing violence.

Variables that may account for the moderating effect of maternal substance abuse of the relation of youth violence exposure and symptoms of posttraumatic stress disorder were explored in the final step of the regression equations of each model. It was hypothesized that maternal substance abuse would be related to a number of detrimental parenting characteristics, including decreased parental support, lower felt acceptance by child, decreased warmth, inadequate monitoring, and poorer maternal psychological functioning.

Results

The FADS use types were dichotomized to examine Type A users versus all others. This approach was taken for several reasons. Initial analyses examined the FADS use types by dichotomizing the variable by Type A and B users versus Types C, D, and E. This approach yielded marginal effects suggesting that clustering Type A and Type B substance use types may have prevented actual effects from being detected. Type A's have experienced the most severe problems in relation to their substance use (i.e. legal, family) so it would be expected that children of Type A substance users would suffer more severe costs of parental substance use than children of Type B users. Additionally, the decision to dichotomize the FADS was made because examining the five FADS use types separately would have resulted in a reduction of power especially when testing the interaction terms.

Additionally, maternal alcohol use type and drug use type were examined separately. The decision to examine maternal alcohol and drug patterns separately was made based on the assumption that the associated problems differ widely by alcohol use versus illicit drug use. Initial analyses combining FADS alcohol and drug types supported this assumption. Mothers who were classified as Type A alcohol users (as discussed below) exhibited poorer functioning in different domains than did Type A drug users.

Descriptive statistics and associations among variables

Table 6 presents descriptive information on and correlations among continuous variables, including child's age, violence exposure, and PTSD symptoms. As seen in

Table 6 higher levels of violence exposure and younger age were associated with higher levels of PTSD symptoms. In addition, higher levels of victimization were associated with higher levels of witnessing violence. Older children were more likely to report higher levels of witnessed violence and lower levels of PTSD symptoms

Chi-square analyses were employed to examine differences in categorical variables. Results showed that child gender was not related to either parent's alcohol or drug type as classified by the FADS indicating that males and females had equal chances of having a parent classified as Type A for alcohol or drug use, χ^2 (1, 309) < 3.841, $p >$ .05. Over half of mothers classified as Type A for alcohol use (53.8%) were also classified as Type A for drug use, while less than 5 percent of mothers classified as non-

Table 6

Correlations Among and Descriptive Statistics on Study Variables

Variable	2	3	4	*M*	*SD*
1. Child Age	.04	.14*	-.14*	12.13	1.62
2. Victimization	--	.42***	.47***	1.94	2.06
3. Witnessed Violence	--	--	.31***	10.75	7.24
4. PTSD Symptoms	--	--	--	7.57	5.90

*$p < .05$, ** $p < .01$, *** $p < .00$

Type A for alcohol use were classified as Type A for drug use (4.4%). A 2 x 2 chi-square analysis indicated that this difference was significant, χ^2 (1, N = 309) = 50.31, $p <$

.001. A significantly larger proportion of youth with a mother classified as Type A for alcohol use (53.8%) had a father classified as Type A for alcohol use compared to those whose mother reported non-Type A alcohol use (17.2%; χ^2 (1, 309) = 10.95, $p < .01$). Similarly, a significantly larger proportion of youth with a mother classified as Type A for alcohol use (46.2%) had a father classified as Type A for drug use compared to those whose mother reported non-Type A alcohol use (18.6%; χ^2 (1, 309) = 5.98, $p < .05$).

In terms of patterns of mothers' Type A drug use, a significantly larger proportion of youth with a mother classified as Type A for drug use (40%) had a father classified as Type A for drug use compared to those whose mother was classified as non-Type A for drug use (18.3%; χ^2 (1, 309) = 5.54, $p < .05$). While a larger proportion of youth with a mother classified as Type A for drug use (35.0%) had a father classified as Type A for alcohol use compared to those whose mother was classified as non-Type A for drug use (17.6%), this difference was not statistically significant, χ^2 (1, 309) = 3.69, $p > .05$. Further, a significantly larger proportion of fathers classified as Type A for alcohol use (53.4%) were also classified as Type A for their drug use compared to fathers classified as non-Type A for alcohol use (12.0%; χ^2 (1, 309) = 51.20, $p < .001$).

Table 7 presents the means, standard deviations, and sample sizes for child age, violence exposure, and PTSD symptoms by gender. As shown in the Table 7, gender differences were present; boys reported experiencing greater rates of victimization.

Table 7

Differences in Study Variables by Gender

	Male (n = 147) *M (SD)*	Female (n = 162) *M (SD)*	t-value
Child Age	12.01 (1.59)	12.14 (1.61)	-0.74
Victimization	2.39 (2.31)	1.50 (1.72)	3.81**
Witnessed Violence	11.00 (7.25)	10.23 (7.27)	0.92
PTSD Symptoms	7.59 (5.84)	7.48 (6.06)	0.11

*$p < .01$, **$p < .001$

Means, standard deviations, and samples sizes for child age, violence exposure, and PTSD symptoms by mother's FADS type are presented in Tables 8 and 9. As seen in the tables, older children were more likely to have mothers who were classified as Type A for alcohol or drug use. Results also revealed that there were not significant differences in the frequency of victimization or witnessing violence between children of mothers who were Type A alcohol users compared to children of non-Type A alcohol users. However, the patterns were different when comparing children of mothers who were Type A drug users to children of mothers who were non-Type A drug users. While there were no significant differences in levels victimization, children of mothers who were Type A drug users reported higher rates of witnessed violence than children of mothers classified as non-Type A drug users. Additionally, youth PTSD symptoms did not differ significantly by mother's FADS type.

Table 8

Differences in Study Variables by Mother's FADS Alcohol Type

	Type A (n = 13) *M (SD)*	Non-Type A (n = 296) *M (SD)*	t-value
Child Age	13.54 (1.51)	12.01 (1.57)	-3.43*
Victimization	2.31 (2.10)	1.91 (2.07)	-0.68
Witnessed Violence	11.18 (5.54)	10.57 (7.33)	-0.29
PTSD Symptoms	10.54 (8.07)	7.38 (5.82)	-1.39

*$p < .01$

Table 9

Differences in Study Variables by Mother's FADS Drug Type

	Type A (n = 20) *M (SD)*	Non-Type A (n = 289) *M (SD)*	t-value
Child Age	12.95 (1.70)	12.02 (1.58)	-2.55**
Victimization	2.53 (1.95)	1.88 (2.07)	-1.36
Witnessed Violence	14.39 (6.13)	10.33 (7.26)	-2.44*
PTSD Symptoms	9.90 (4.85)	7.35 (5.99)	-1.86

*$p < .05$, **$p \leq .01$

The means, standard deviations, and samples sizes of possible mediating variables by maternal FADS type are provided in Tables 10 and 11. Results indicated that children of Type A alcohol or drug using mothers were significantly different from children of non-Type A using mothers on several common variables. Children of Type A users reported lower levels of parental knowledge, child disclosure, and parental control. Additionally, mothers who were Type A alcohol users, but not mothers who were Type A drug users, reported significantly more symptoms of depression and anxiety compared to non-Type A users. These mothers also indicated significantly higher use of coping via behavioral, mental, and alcohol-drug disengagement strategies. Children of mothers who were Type A drug users also reported significantly lower levels of parental solicitation, felt acceptance, and social support from their mothers than did children of mothers who were non-Type A drug users. Furthermore, mothers who were Type A drug users indicated that they experienced a higher average severity of stressors than non-Type A drug users.

Table 10

Differences in Possible Mediating Variables by Maternal Alcohol Type

	Type A (N = 13)		Non-Type A (N = 292)		
	M	(*SD*)	*M*	(*SD*)	t - value
Parental Knowledge	34.00	(7.11)	38.03	(6.07)	2.24*
Child Disclosure	16.42	(5.78)	19.91	(4.49)	2.61*
Parental Solicitation	13.83	(5.86)	16.52	(5.11)	1.78+
Parental Control	20.00	(3.84)	22.67	(3.28)	2.74**
Somatization - BSI	11.77	(5.02)	11.32	(4.98)	0.32
Depression - BSI	12.46	(6.13)	9.63	(4.54)	2.16*
Anxiety - BSI	12.77	(5.86)	9.76	(4.34)	2.41*
Hostility - BSI	9.31	(4.42)	8.54	(3.45)	0.78
Felt Acceptance	45.64	(10.98)	50.13	(6.75)	1.46
Avg Severity of Maternal Stressors	11.15	(6.31)	10.34	(6.11)	0.47
Social Support from Mom	26.11	(7.14)	27.98	(5.72)	1.10
Active Coping - COPE	11.38	(2.93)	11.58	(2.79)	0.25
Planning - COPE	12.54	(2.67)	12.46	(2.93)	0.09

(Table Continues)

Table 10 (Continued)

	Type A (N = 13)		Non-Type A (N = 292)		
	M	*(SD)*	*M*	*(SD)*	t - value
Seek Social Support for Instrumental Reasons - COPE	11.62	(3.10)	10.90	(3.12)	0.81
Seek Social Support for Emotional Reasons - COPE	12.69	(3.07)	11.07	(3.17)	1.79+
Positive Reinterpretation - COPE	13.08	(2.25)	12.43	(2.77)	0.82
Turning to Religion - COPE	15.15	(1.95)	14.32	(2.52)	1.18
Focus on & Venting of Emotions - COPE	11.00	(3.49)	9.85	(2.98)	1.35
Denial - COPE	7.85	(2.44)	6.69	(2.82)	1.45
Behavioral Disengagement - COPE	8.85	(2.97)	6.67	(2.29)	3.31**
Mental Disengagement - COPE	10.62	(1.80)	8.65	(2.47)	2.84**
Alcohol-drug Disengagement - COPE	7.08	(4.25)	4.53	(1.55)	2.15*
Difficulty Identifying Feelings - Alexithymia	14.31	(7.00)	11.74	(5.66)	1.59

(Table Continues)

Table 10 (Continued)

	Type A (N = 13)		Non-Type A (N = 292)		
	M	(*SD*)	*M*	(*SD*)	t - value
Difficulty Describing Feelings - Alexithymia	10.00	(4.16)	11.08	(4.56)	0.84
Externally Oriented Thinking - Alexithymia	19.62	(4.54)	18.53	(4.52)	1.08

$+p < .10$, $*p \leq .05$, $**$ $p < .01$, $***$ $p < .001$

Table 11

Differences in Possible Mediating Variables by Maternal Drug Type

	Type A (N = 20)		Non-Type A (N = 284)		
	M	(*SD*)	*M*	(*SD*)	t - value
Parental Knowledge	32.47	(7.88)	38.23	(5.87)	3.12**
Child Disclosure	16.16	(5.29)	20.04	(4.44)	3.64***
Parental Solicitation	13.42	(4.19)	16.60	(5.16)	2.63**
Parental Control	20.16	(3.76)	22.71	(3.25)	3.28**
Somatization - BSI	11.80	(5.43)	11.28	(4.94)	0.45
Depression - BSI	10.35	(4.06)	9.71	(4.70)	0.59
Anxiety - BSI	11.25	(5.00)	9.79	(4.40)	1.42
Hostility - BSI	8.70	(2.77)	8.54	(3.53)	0.20
Felt Acceptance	44.25	(9.95)	50.34	(6.62)	2.70*
Avg Severity of Maternal Stressors	12.95	(5.97)	10.18	(6.09)	1.97*
Social Support from Mom	23.79	(6.58)	28.16	(5.63)	3.24**
Active Coping - COPE	11.15	(2.72)	11.60	(2.80)	0.69
Planning - COPE	12.30	(2.98)	12.46	(2.91)	0.24

(Table Continues)

Table 11 (Continued)

	Type A (N = 13)		Non-Type A (N = 292)		
	M	(*SD*)	*M*	(*SD*)	t - value
Seek Social Support for Instrumental Reasons - COPE	11.55	(3.38)	10.87	(3.09)	0.95
Seek Social Support for Emotional Reasons - COPE	10.70	(3.63)	11.18	(3.15)	0.66
Positive Reinterpretation - COPE	13.10	(2.86)	12.40	(2.73)	1.10
Turning to Religion - COPE	15.05	(2.06)	14.30	(2.53)	1.30
Focus on & Venting of Emotions - COPE	10.50	(3.49)	9.84	(2.95)	0.96
Denial - COPE	7.05	(2.58)	6.72	(2.84)	0.50
Behavioral Disengagement - COPE	7.55	(2.48)	6.71	(2.34)	1.53
Mental Disengagement - COPE	9.70	(2.64)	8.66	(2.46)	1.82+
Alcohol-drug Disengagement - COPE	5.95	(3.47)	4.54	(1.59)	1.81+
Difficulty Identifying Feelings - Alexithymia	12.65	(6.48)	11.78	(5.69)	0.66

(Table Continues)

Table 11 (Continued)

	Type A (N = 13)		Non-Type A (N = 292)		
	M	(*SD*)	*M*	(*SD*)	t - value
Difficulty Describing Feelings - Alexithymia	12.05	(3.38)	10.96	(4.62)	1.04
Externally Oriented Thinking - Alexithymia	19.90	(4.08)	18.21	(4.51)	1.63

$+p < .10$, $*p \leq .05$, $**\ p < .01$, $***\ p < .001$

Variables that were significantly different by mother's alcohol or drug type were included in the respective regression equations to determine if they played a mediating role in the relation between violence exposure and PTSD outcomes.

Relations among violence exposure, parental substance use, and PTSD symptoms

The associations of mother's alcohol use and mother's drug use with PTSD symptoms following victimization or witnessing violence were examined in four separate regression equations. All continuous predictor and moderator variables were centered (i.e. the mean was subtracted) and interaction terms were computed from the centered variables to maximize interpretability and minimize potential problems with multicollinearity (Aiken & West, 1991). For each regression equation, the child's age and gender were entered in the first step to control for their effects. The child's biological father's FADS alcohol and drug type variables were then entered at the second step to examine their relation to adjustment. The violence exposure variable (victimization or witnessing) and the moderator (maternal alcohol type or drug type) were entered in the third and fourth steps, respectively, to account for main effects. The fifth step of the regression included a two-way interaction term between the violence exposure variable and the moderator. The change in R^2 as a function of the interaction term was examined to determine the significance of moderation effects. When significant, interactions were plotted using recommendations of Aiken and West (1991). Possible mediators of the relation between maternal substance use history and PTSD symptoms were entered in the sixth and final step of the regression.

Regression analyses with maternal alcohol use

Table 12 presents regression results predicting PTSD symptoms levels from victimization, maternal alcohol use type, and controls (selecting for maternal caregiver as biological mom and excluding responses of "don't know" for one's alcohol use type). As seen in the table, with respect to the demographic variables in the first step, younger children reported more PTSD symptoms. Following step 2, father's FADS alcohol and drug types did not have a significant association with PTSD symptoms. Results of step 3 indicated that victimization was positively associated with PTSD symptoms. Additionally, step 4 revealed a significant main effect of maternal FADS alcohol use type on PTSD symptoms; children of mothers who were Type A for alcohol use reported more PTSD symptoms. While the overall model remained significant, step 5 indicated that the interaction of victimization and maternal FADS alcohol use type was not significant. Thus, these predictors independently, but not conjointly, contributed to higher levels of PTSD symptoms. Possible mediating variables were entered at step 6, of which only parental knowledge accounted for a significant portion of the variation in youth PTSD symptoms. The addition of this possible mediator did not significantly reduce the association of maternal alcohol type with PTSD symptoms, suggesting that parental knowledge serves as an independent contributor to youth PTSD symptoms.

Table 13 presents regression results predicting PTSD symptom levels from witnessed violence, maternal alcohol use type, and controls (selecting for maternal

Table 12

Regression Analysis Predicting PTSD Symptom Levels from Victimization, Maternal Alcohol Use Type, and Controls

		At step			Final step		
	ΔR^2	*B*	*SE B*	β	*B*	*SE B*	β
Step 1	.02						
Age		-.49	.21	-.13*	-.80	.20	-.22***
Gender		-.13	.68	-.01	1.43	.62	.12*
Step 2	.00						
Father Alc Type A		-.74	.95	-.05	-1.61	.84	-.11*
Father Drug Type A		.34	.93	.02	.82	.81	.06
Step 3	.24***						
Victimization		1.47	.15	.51***	1.35	.17	.47***
Step 4	.01*						
Mother Alc Type A		3.66	1.56	.12*	3.27	1.67	.11*
Step 5	.00						
Vict X Mom Alc Type A		.06	.73	.00	.29	.75	.02
Step 6	.04*						
Parental Knowledge					-.21	.07	-.23**
Child Disclosure					.13	.10	.10

(Table Continues)

Table 12 (Continued)

	At step			Final step		
	ΔR^2	*B*	*SE B*	β	*B*	*SE B*	β
Step 6 (Continued)							
Parental Control					-.05	.11	-.03
Depression -BSI					-.10	.10	-.08
Anxiety -BSI					.07	.10	.05
Behavioral Disengagement -COPE					-.18	.15	-.07
Mental Disengagement -COPE					.13	.14	.06
Alcohol-Drug Disengagement -COPE					.06	.18	.02

Note: *B* = unstandardized regression coefficient. β = standardized regression coefficient.

$R^2 = .31$, $F(15, 280) = 8.46$, $p < .001$.

$+p < .10$; * $p \leq .05$; ** $p < .01$; *** $p < .001$.

caregiver as biological mom and excluding responses of "don't know" for one's alcohol use type). As indicated in the table, in regard to the demographic variables entered at step 1, younger children reported more PTSD symptoms. After step 2, father's FADS alcohol and drug types did not predict PTSD symptoms. Results of step 3 indicated that witnessing violence was positively associated with PTSD symptoms. Additionally, step 4 revealed a significant main effect of mother's FADS alcohol type on PTSD symptoms; children of mothers who were Type A for alcohol use reported more PTSD symptoms. Furthermore, step 5 indicated that witnessing violence and mother's FADS alcohol type interacted to predict PTSD symptoms. The Victimization X mother's FADS alcohol type interaction is plotted in Figure 1 and revealed that, at low levels of witnessed violence, mother's alcohol use type is not associated wtih PTSD symptoms; however, as levels of witnessed violence increase, having a mother who is classified as Type A for alcohol was associated with higher levels of PTSD symptoms. Step 6 included possible mediating variables identified through the t-tests presented in Table 10. Parental knowledge emerged as the only significant mediating variable to explain the moderating relation of maternal alcohol use history on PTSD symptoms following witnessed violence. As in the previous model, the addition of parental knowledge did not reduce the association of maternal alcohol use type implicating parental knowledge as an independent contributor to PTSD symptoms rather than a mediator.

Regression analyses with maternal drug use

Table 14 presents regression results predicting PTSD symptom levels from victimization, maternal drug use type, and controls (selecting for maternal caregiver as

Table 13

Regression Analysis Predicting PTSD Symptom Levels from Witnessed Violence, Maternal Alcohol Use Type, and Controls

		At step			Final step		
	ΔR^2	*B*	*SE B*	β	*B*	*SE B*	β
Step 1	.02						
Age		-.49	.21	-.13*	-.94	.21	-.25***
Gender		-.13	.68	-.01	.53	.64	.05
Step 2	.00						
Father Alc Type A		-.74	.95	-.05	-1.79	.88	-.12*
Father Drug Type A		.34	.93	.02	.41	.85	.03
Step 3	.12***						
Witnessed Violence		.28	.05	.35***	.23	.05	.29***
Step 4	.02**						
Mother Alc Type A		4.69	1.68	.16**	4.14	1.71	.14*
Step 5	.01*						
Witnessed X Mom Alc Type A		.59	.29	.11*	.72	.29	.14*
Step 6	.07**						
Parental Knowledge					-.26	.08	-.27**
Child Disclosure					-.01	.10	-.01

(Table Continues)

Table 13 (Continued)

	At step			Final step		
	ΔR^2	*B*	*SE B*	β	*B*	*SE B*	β
Step 6 (Continued)							
Parental Control					.06	.12	.03
Depression -BSI					-.03	.11	-.02
Anxiety -BSI					.06	.11	.04
Behavioral Disengagement -COPE					-.21	.16	-.08
Mental Disengagement -COPE					.01	.15	.00
Alcohol-Drug Disengagement -COPE					-.06	.19	-.02

Note: *B* = unstandardized regression coefficient. β = standardized regression coefficient.

$R^2 = .24$, $F(15, 280) = 5.80$, $p < .001$.

$+p < .10$; * $p \leq .05$; ** $p < .01$; *** $p < .001$.

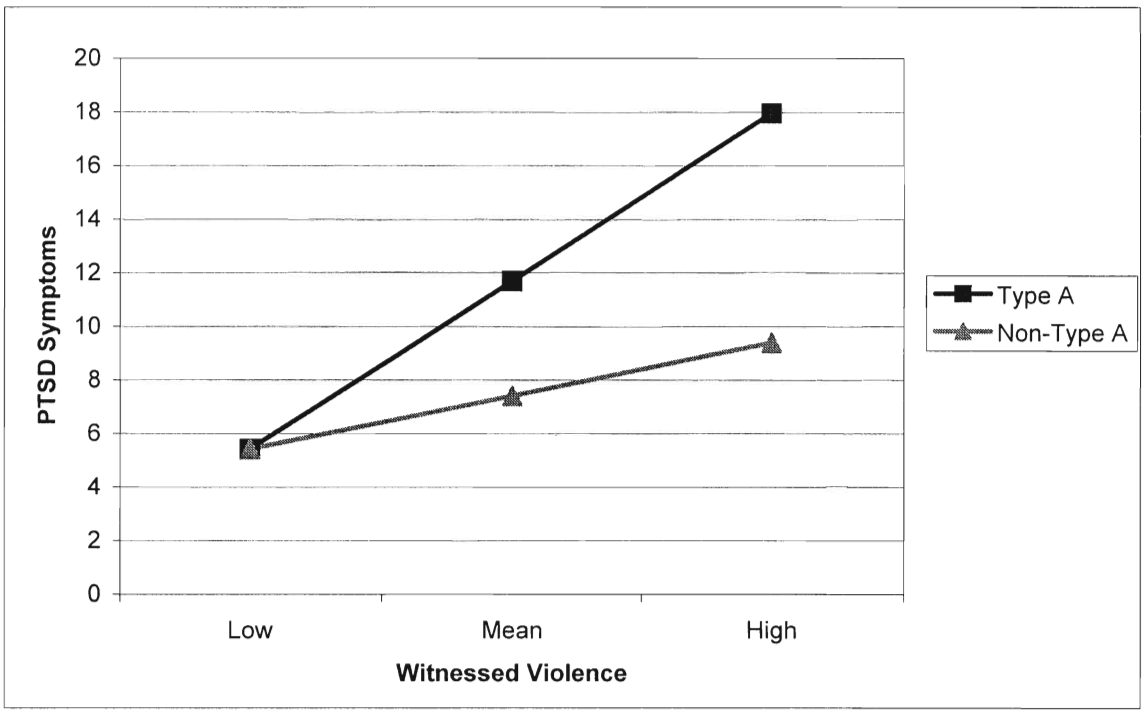

Figure 1. PTSD symptom level as a function of frequency of witnessed violence and mother's FADS Alcohol Type.

biological mom and excluding responses of "don't know" for one's drug use type). Step 1 indicated that younger children reported more PTSD symptoms. Step 2 suggested that father's FADS alcohol and drug types were not associated with PTSD symptoms. Results of step 3 revealed a significant main effect of the association of victimization with PTSD symptoms; victimization was positively associated with PTSD symptoms. Step 4 indicated that there was a trend toward significance of the association of mother's FADS drug type with PTSD symptoms; children whose mothers were Type A for drug use reported marginally higher levels of PTSD symptoms. While the overall model remained significant, step 5 indicated that the interaction of victimization and mother's FADS drug use type was not significant. The final step examined possible mediating variables of the relation between maternal drug use type and PTSD symptoms. Of the possible mediating variables, only parental knowledge accounted for a significant portion of the variation in youth PTSD symptoms.

Table 15 presents regression results predicting PTSD symptom levels from witnessed violence, maternal drug use, and controls (selecting for maternal caregiver as biological mom and excluding responses of "don't know" for one's drug use type). Similar to the previous models, step 1 revealed that younger children reported more PTSD symptoms and step 2 suggested that father's FADS alcohol and drug types did not contribute to PTSD symptoms. The model became significant at step 3 with the addition of the witnessed violence variable; children who reported higher levels of witnessed violence indicated more PTSD symptoms. The model remained significant at steps 4 and 5; however, there was not a main effect for the association of mother's FADS drug type,

Table 14

Regression Analysis Predicting PTSD Symptom Levels from Victimization, Maternal Drug Use Type, and Controls

		At step			Final step		
	ΔR^2	*B*	*SE B*	β	*B*	*SE B*	β
Step 1	.02						
Age		-.48	.21	-.13*	-.73	.20	-.20***
Gender		-.16	.67	.01	1.58	.63	.14*
Step 2	.00						
Father Alc Type A		-.68	.94	-.05	-1.32	.83	-.09
Father Drug Type A		.15	.92	.01	.78	.81	.05
Step 3	.22***						
Victimization		1.41	.16	.48***	1.29	.17	.44***
Step 4	.01						
Mother Drug Type A		2.12	1.24	.09+	1.53	1.32	.07
Step 5	.00						
Vict X Mom Drug Type A		-.07	.63	-.01	.18	.63	.02
Step 6	.05*						
Parental Knowledge					-.25	.08	-.27**
Child Disclosure					.14	.11	.11

(Table Continues)

Table 14 (Continued)

	At step			Final step		
	ΔR^2	*B*	*SE B*	β	*B*	*SE B*	β
Step 6 (Continued)							
Parental Solicitation					-.03	.07	-.03
Parental Control					-.04	.11	-.02
Felt Acceptance					.02	.05	.02
Avg Severity of Maternal Stressors					-.06	.05	-.07
Social Support from Mom					.07	.06	.07

Note: *B* = unstandardized regression coefficient. β = standardized regression coefficient.

$R^2 = .29$, $F(14, 278) = 8.15$, $p < .001$.

$+p < .10$; * $p \leq .05$; ** $p < .01$; *** $p < .001$.

although a trend was evident, and the interaction of witnessed violence and mother's FADS drug type also was not significant. As in the three previous regression equations, step 6 revealed that, of the possible mediating variables, only parental knowledge accounted for a significant portion of variance in PTSD symptoms. Additionally, just as in the previous model predicting PTSD symptoms from victimization, maternal drug use type, and controls, parental knowledge further reduced the association of maternal drug type on PTSD symptoms implicating it as a mediator in the relation between maternal drug use type and PTSD symptoms.

Table 15

Regression Analysis Predicting PTSD Symptom Levels from Witnessed Violence, Maternal Drug Use Type, and Controls

		At step			Final step		
	ΔR^2	*B*	*SE B*	β	*B*	*SE B*	β
Step 1	.02						
Age		-.48	.21	-.13*	-.84	.21	-.23***
Gender		-.16	.67	.01	.73	.64	.06
Step 2	.00						
Father Alc Type A		-.68	.94	-.05	-1.60	.88	-.11+
Father Drug Type A		.15	.92	.01	.59	.85	.04
Step 3	.12***						
Witnessed Violence		.28	.04	.35***	.22	.05	.28***
Step 4	.01						
Mother Drug Type A		2.25	1.32	.10+	.01	1.54	.00
Step 5	.01						
Wit X Mom Drug Type A		.27	.21	.09	.32	.21	.10
Step 6	.07**						
Parental Knowledge					-.27	.08	-.28**
Child Disclosure					-.001	.11	-.001

(Table Continues)

Table 15 (Continued)

	At step			Final step		
	ΔR^2	*B*	*SE B*	β	*B*	*SE B*	β
Step 6 (Continued)							
Parental Solicitation					-.03	.08	-.03
Parental Control					.06	.11	.04
Felt Acceptance					-.03	.06	-.04
Avg Severity of Maternal Stressors					-.02	.05	-.02
Social Support from Mom					.07	.07	.07

Note: *B* = unstandardized regression coefficient. β = standardized regression coefficient.

$R^2 = .22$, $F(14, 278) = 5.58$, $p < .001$.

$+p < .10$; * $p \leq .05$; ** $p < .01$; *** $p < .001$.

Discussion

The current study aimed to better understand the relation between violence exposure and PTSD symptoms in urban youth, with a focus on maternal substance use as both a direct contributor to PTSD symptoms and a moderator of the violence exposure – PTSD association. Specifically, the study assessed whether having a mother who was classified as having a history of severe alcohol or drug use would exacerbate the association between violence exposure and PTSD symptoms.

Violence Exposure and PTSD Symptoms

As hypothesized, youth who experienced greater levels of victimization and witnessed violence reported more PTSD symptoms than youth who reported lower levels of victimization and witnessed violence. This relation is widely supported by previous studies (e.g. Fitzpatrick and Boldizar, 1993; Hanson et al., 2006b; Ozer & Weinstein, 2004). A diagnosis of PTSD requires exposure to a traumatic event in which the individual "experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others" (APA, 2000). Direct victimization and witnessed violence both qualify as traumatic events under this criterion; therefore, an increased rate of PTSD symptom endorsement would be expected by youth who met either condition. Additionally, results revealed that the relation between violence exposure and PTSD symptoms was stronger for direct victimization than for witnessed violence. This finding is supported by previous research (e.g. Paxton, Robinson, Shah, & Schoeny, 2004), which has shown that more direct forms of violence exposure result in greater psychological distress.

Gender and PTSD Symptoms

The hypothesis that the levels of PTSD symptoms would vary by gender, with females displaying a stronger association between violence exposure and PTSD symptoms, was also supported. After controlling for the level of violence exposure, the association between violence exposure and PTSD symptoms was significantly stronger for girls than for boys. However, this held true only for the models examining victimization. Prior research supports the finding that females are more likely than males to develop PTSD symptoms subsequent to violence exposure (e.g. Davis & Siegel, 2000; Jaycox et al., 2004; Linning & Kearney, 2004; Stoppelbein & Greening, 2000). Most studies examining the relation of victimization and witnessed violence to PTSD symptoms by gender in the same study do so without differentiating the gender associations with each specific type of violence exposure. However, one previous study corroborates the current findings. Springer and Padgett (2000) found that while direct victimization in the community was a much stronger predictor of PTSD symptoms in females than males, females in their sample were not more likely than males to experience PTSD symptoms in association with witnessed violence (Springer & Padgett, 2000). The current findings suggest that females may benefit more than males from treatments that address direct victimization while both genders will benefit from interventions that target witnessed violence.

Maternal Substance Abuse and PTSD Symptoms

As predicted, a positive history of maternal substance abuse was related to higher PTSD symptom levels than no history of maternal substance abuse. However, this

hypothesis was only partially supported by the data. After controlling for child's age, child's gender, father's alcohol and drug use type, and violence exposure level, the relation of a positive history of maternal substance abuse to higher PTSD symptoms was significant only for children of mothers who were classified as Type A alcohol users and not children of mothers who were classified as Type A drug users. This finding corroborates previous studies that have shown that children from families with alcohol-abusing parents experience higher levels of anxiety (e.g. Chassin, Rogosch, & Barrera, 1991; Dobkin, Tremblay, Desmarais-Gervais, & Depelteau, 1994; Lynskey, Fergusson, & Horwood, 1994).

Children of mothers classified as Type A drug users did not differ significantly from children of mothers classified as non-Type A drug users on symptoms of PTSD. This may have been due to the relatively small sample size (n=20) as the difference approached significance. Future studies should explore this question with a sample that includes a larger number of mothers classified as having a positive history of drug abuse. Another possible explanation for the finding that a positive history of maternal alcohol abuse, but not drug abuse, was related to higher PTSD symptom levels is that maternal alcohol abuse has more severe consequences for youth in regard to PTSD than does maternal drug use; yet, this is unclear. While most research examining the psychological consequences for children of substance abusing parents has focused on children of alcoholics, some researchers have studied the outcomes for children of parents who abuse illicit drugs and have produced similar results. Clark and colleagues (1997) found that sons of drug abusing fathers had increased rates of anxiety compared to sons of non-drug

abusing fathers. In addition, Wilens and colleagues (1995) found that, compared to children of controls, children of parents with opioid dependence had significantly elevated overall internalizing scores on the CBCL. While children of both alcohol and drug abusers are at increased risk for internalizing disorders, few studies have directly examined the differences in outcomes by parent alcohol versus other drug abuse. Hanson et al. (2006b) examined the outcomes of parent alcohol and drug use separately and found parental alcohol use (OR=3.29) was a stronger predictor of adolescent PTSD than parental drug use (OR=2.10). However, conclusions drawn from these results must be made cautiously as the parental alcohol and drug use variables were obtained by asking adolescents questions to determine if anyone in their family had problems with drugs or alcohol with a follow up question to assess the adolescent's relationship to this family member. It is quite probable that adolescents would not accurately identify their parents' alcohol and drug use patterns as parents likely limit their children's exposure to such use, especially the use of illicit drugs.

Alternatively, the lack of significant findings in regard to differences in PTSD symptoms between children of mothers classified as Type A drug users versus children of non-Type A drug users could be a result of the self-report nature of the substance use items. It is possible that heavier drug users minimized the severity of their use more so than heavy alcohol users because of legal and social implications of drug use. Furthermore, the FADS is a measure of lifetime substance use and classifies individuals by the heaviest use in their lifetime. Consequently, it is possible that a greater portion of the mothers classified as Type A for their drug use history would not currently meet

criteria for Type A use and, therefore, their children's current adjustment may not be affected by their past use.

Violence Exposure, Maternal Substance Abuse, and PTSD Symptoms

The hypothesis that a history of maternal substance abuse would moderate the relation between violence exposure and PTSD symptom in youth was partially supported. However, this association varied according to the type of substance abuse examined and the type of violence exposure. A maternal history of substance abuse explained the relation between violence exposure and PTSD symptom levels, but this relation was only true for the model predicting PTSD symptom levels from witnessed violence, maternal alcohol use, and controls. Children who witnessed violence and whose mother had a history of alcohol abuse were more susceptible to developing PTSD than children who witnessed violence and whose mother did not have a history of alcohol abuse. However, this association was not true at low levels of violence exposure; children of mothers with a history of alcohol abuse endorsed similar levels of PTSD symptoms as children whose mother did not have a history of alcohol abuse at low levels of witnessed violence. As the levels of witnessed violence increased, the levels of PTSD symptoms increased at greater rates for children of mothers with a history alcohol abuse. This suggests that a maternal history of alcohol abuse multiplies, rather than merely adds to, risk for PTSD symptoms among youth exposed to community violence.

It is only in the case of witnessing violence that maternal alcohol use exacerbates the impact of violence exposure. The lack of significant results for the other three models examining the interaction of violence exposure and maternal substance use may be a

result of the reduced statistical power due to a relatively small number of mothers classified as Type A alcohol or drug users. Restricted power becomes a significant issue when trying to detect interaction effects (Cohen, Cohen, West, & Aiken, 2003).

The current findings confirm and extend the recent findings of Hanson and colleagues (2006b) regarding the moderating role of parental substance abuse in the relationship between youth violence exposure and PTSD symptomatology. Similar to the study conducted by Hanson et al. (2006b), the current study found that maternal alcohol abuse history interacted with witnessed violence to produce more severe PTSD symptom levels. While Hanson et al. (2006b) examined the associations of parental alcohol or drug abuse and sexual abuse, physical abuse, or witnessed violence with PTSD diagnosis, the only significant interaction was between witnessed violence and parental alcohol abuse. However, Hanson and colleagues (2006b) did not differentiate between the effects of maternal and paternal alcohol and drug abuse, as did the current study. Additionally, they did not attempt to examine possible variables that may explain this interaction.

Parental Knowledge and PTSD Symptoms

While the hypothesis that deficient parenting and poorer psychological functioning of the substance-abusing mother would explain the relation of maternal substance abuse to community violence exposure and PTSD was not supported, parental knowledge emerged as an independent contributor to PTSD symptoms in each of the regression models. This was the only potential mediating variable that was significantly associated with PTSD outcomes in each of the models; children who reported greater parental knowledge also reported lower levels of PTSD symptoms. Similarly, Ceballo

and colleagues (2003) reported that parental monitoring following community violence was an important indicator of other psychological outcomes. While they refer to the construct as parental monitoring, their measure more accurately reflects parental knowledge. The current study extends the previous findings of Ceballo et al. (2003), who found that parental monitoring buffered the effects of violence exposure on depressive symptoms and feelings of hopelessness. However, this positive impact was attenuated at higher levels of victimization. While youth exposed to lower levels of victimization benefited from increased parental monitoring, levels of monitoring were not associated with depressive symptoms or feeling of hopelessness at high levels of victimization. This interaction was not found for witnessing violence.

The current study confirms and extends the earlier findings of Kerr and Stattin (2000) who showed that higher levels of parental knowledge are related to better child adjustment. They specifically examined external maladjustment (i.e. delinquency, school problems, and poor teach relations) internal maladjustment (i.e. depressed mood, low self-esteem, and failure expectations), friends' characteristics (i.e. hang out on the streets and have been caught by police), and family discord (bad mother and father relations) (Kerr & Stattin, 2000). The current study adds to the literature PTSD symptoms as an additional area of child adjustment related to parental knowledge.

The identification of parental knowledge as factor associated with PSTD symptoms following violence exposure has important implications. Higher levels of parental knowledge can buffer youth from the negative consequences of violence exposure and, therefore, serves as an important protective factor for youth. Prevention

programs can target parenting skills as a means of reducing the likelihood that urban adolescents will develop PTSD symptoms in response to violence exposure.

Maternal Substance Abuse and Violence Exposure

While variations in violence exposure by maternal alcohol or drug use type were not directly hypothesized, differences in rates of violence exposure were found when comparing children of Type A mothers versus children of non-Type A mothers. Although, these differences were only detected for youth whose mother's endorsed a positive history of drug abuse; a maternal history of drug abuse was related to higher rates of witnessed violence. However, children of Type A drug users did not significantly differ from children of non-Type A drug users on rates of victimization. Additionally, significant differences were not found between children of Type A alcohol users versus children of non-Type A alcohol users on rates of victimization and witnessed violence. The absence of significant findings for these variables could be attributed to the relatively small number of mothers meeting criteria for Type A alcohol or drug use history. These findings confirm previous studies that found children of drug abusers to face greater opportunities for exposure to violence (e.g. Chaffin, Kelleher, & Hollenberg, 1996; Hanson et al., 2006a). This has important treatment implications as the women entering drug treatment facilities often have children to care for in addition to their own recovery. The mother's entrance to treatment affords the opportunity for early intervention with their children in order to mitigate the effects of violence to which they have been exposed (Van de Mark et al., 2005).

Paternal Substance Abuse and PTSD Symptoms

Another interesting, yet unexpected, finding is the relation of father's FADS alcohol type to youth PTSD symptoms at the final step of three of the regression models. The models predicting PTSD symptom levels from both forms of violence exposure (i.e. victimization and witnessed violence), maternal alcohol use type, and controls indicated that having a father who was classified as a non-Type A alcohol user predicted higher levels of PTSD symptoms for youth. For the model predicting PTSD symptom levels from witnessed violence, maternal drug use type, and controls there was a trend towards an association with fathers classified as non-Type A for alcohol use and higher PTSD symptoms. This relation was not significant and, therefore, conclusions cannot be drawn at this time. However, the relation mentioned for the two previous models was significant at the .05 level, leading to the question why this association is present. This may be a consequence of the nature of the father's substance abuse variable; mothers report on what they view as the fathers' lifetime alcohol and drug use patterns and, hence, the data may not accurately reflect the fathers' actual use patterns. Furthermore, the lack of an association of Type A father to higher PTSD symptoms could be explained by the small percentage of biological fathers actually living in the homes. While a large number of fathers were classified as Type A alcohol or drug users, approximately 10% of these fathers were living in the home at the time of the interview. Of the 55 fathers classified as Type A alcohol users, 6 of them were identified as living within the home and 5 of 60 Type A drug users lived in the home.

Study Limitations, Strengths, and Directions for Future Research

The present study had a number of important limitations. First, the data was correlational and was collected at one point in time. Thus, neither causality nor the direction of associations can be determined, although it is unlikely that youths' PTSD symptoms or violence exposure caused maternal alcohol or other drug use history. Using a longitudinal design would have strengthened the current study. It is also possible that an unexamined confounding variable caused the independent and dependent variables. The likelihood of this was reduced by including possible confounds in the regressions models; however, it is possible that an unmeasured variable contributed to the associations found in the current study.

Second, the study employed self-report questionnaires. Mothers self-reported their substance use history, which may have resulted in inaccurate reporting due to social desirability. However, mothers were likely more accurate reporters than youth of their substance use history. Furthermore, mothers may have feared that disclosure of severe of alcohol or drug use may have led to legal repercussions, especially in regard to child custody. This possibility of this outcome was reduced by the attainment of a Federal Certificate of Confidentiality, which prevented researchers from being required to reveal participant identities and protected them from legal issues. Nevertheless, as indicated in the study consent and assent forms, researchers were required to report to the appropriate authorities any participant disclosure that they may cause injury to themselves or others. This included suspected child or elder abuse.

While the self-report nature of the study was a weakness, efforts were made to minimize its impact. Adolescent participants reported on their adjustment and behaviors and their mother's behaviors. Mothers answered questions regarding their behaviors and adjustment as well as the behavior and adjustment of their adolescent child. While the data was available, the current study did not examine the discrepancies between child-report and parent self-report of mothers' parenting practices, as this was not the focus of the current study. Additionally, prior research suggests that children's reports of parenting behaviors may be more accurate as parent-reported behavior is likely influenced by social desirability biases (Dishion & McMahon, 1998).

Third, the study was limited by the relatively small number of mothers classified as Type A alcohol or drug users; only four percent of mothers were classified as Type A for their alcohol use and nearly 7% were classified as Type A for their drug use. It is possible that this small sample size of Type A users resulted in limited statistical power that prohibited significant findings to fully support the study hypothesis that maternal substance use would moderate the association between violence exposure and PTSD symptoms. As previously mentioned, limited power is a significant concern when trying to detect interaction effects (Cohen, Cohen, West, & Aiken, 2003). However, it should be noted that even with such a small percentage of the sample meeting criteria for Type A alcohol use, the hypothesis of moderation was supported for the model predicting PTSD symptom levels from witnessed violence, maternal alcohol use type, and controls. Future studies should examine this question of moderation with a sample that includes a larger percentage of mothers who meet criteria for Type A alcohol or drug use history.

Furthermore, as previously mentioned, the current study is limited through its examination of maternal substance abuse using a measure of most severe lifetime alcohol and drug use rather than current status. It is quite possible that the mothers classified as Type A users would not currently meet this criteria. Future studies should include a measure of current use severity in order to gain a snapshot of recent substance use patterns. Such a measure would provide a more accurate representation of the family climate than would a measure of lifetime substance use severity.

Also, the current study only examined the relation of violence exposure and PTSD symptoms. However, as discussed in the introduction, PTSD can result from any traumatic experience that involves "actual or threatened death or serious injury, or a threat to the physical integrity of self or others" (APA, 2000). This encompasses other traumatic events such at natural and man-made disasters (e.g. earthquakes, fires), serious disease (e.g. cancer) or life-threatening injury, automobile accidents, rape, and exposure to domestic violence. It is likely that some of the youth in the current study exhibited PTSD symptoms in response to some of these other unmeasured traumatic events and this may have limited the findings.

Despite these limitations, there are several important strengths of the current study. First, the data was based on multiple reporters; both child and mother data were used in the current analyses. Secondly, the data represents a community sample rather than a clinical sample. Rates of PTSD would be expected to be higher than normal in clinical samples.

An additional strength of the current study is the use of the parental knowledge measure, rather than a measure of parental monitoring. Previous research has suggested that common parental monitoring measures fail to ask about parental efforts to actively track and supervise their children (Kerr & Stattin, 2000; Stattin & Kerr, 2000). Instead, these measures inquire about parents' knowledge of their children's activities and may more accurately reflect children's comfort and desire to share information with their parents rather than parents' monitoring behaviors (Kerr & Stattin, 2000; Stattin & Kerr, 2000). Kerr and Stattin (2000; Stattin & Kerr, 2000) suggest that parental knowledge about their adolescent's daily activities is obtained through child disclosure, parental solicitation, and parental control. The current study differentiated between parental knowledge, child disclosure, parental solicitation, and parental control.

It is clear from the lack of published research articles that additional work is required in this area. Specifically, future studies should be constructed longitudinally as to control for prior levels of community violence exposure and symptoms of posttraumatic stress disorder. Additionally, researchers should attempt to collect information on family and neighborhood characteristics, as well as individual traits. Efforts should also be made to incorporate wider age ranges so that developmental issues can be addressed. Children's acquisition of additional coping skills and other developmental changes may interact with other mediators of violence exposure and PTSD to produce varied outcomes across childhood.

Additionally, it is important to note that while youth in current study reported on average about two victimization events in their lifetime and witnessed approximately 11

violent events, the majority did not report high levels of PTSD symptoms. This suggests that they were on average able to effectively cope with the trauma that they experienced. These children were exhibiting resilience in the face of difficult life circumstances. Above all, it is important that researchers work to identify protective factors that prevent youth from developing PSTD after exposure to violence

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APPENDIX 1A:

DEMOGRAPHICS

Q1. [Circle Gender of Child Here] M F

The first thing we want to do is learn more about you and your family.

Q2. How old is (*name of child*)? _____ [in years]

Q3. What is his/her date of birth? _____/_____/_____
mm dd yyyy

Q4. What is your relationship to *(child)*? Are you his/her:

1. Natural (Biological) Mother
2. Adopted Mother
3. Stepmother
4. Father's Girlfriend
5. Grandmother
6. Other Female Relative
   6a. (specify)_____
7. Other
   7a. (specify) _____

APPENDIX 1B:

SURVEY OF CHILDREN'S EXPOSURE TO VIOLENCE

Now I am going to ask you a lot of very specific questions about different kinds of violence, and things related to violence, that you may have experienced, seen, or heard about. For each question, point to or tell me the one that best describes your experience. You can just tell me the number if you want. ***Do <u>NOT</u> include in your answers things you may have seen or heard about only on TV, radio, the news, or in the movies.***

[Refer to Student Answer Choices]

BEING CHASED

Q26a. How many times have *you yourself* been chased by gangs or older kids? [26a]_____

Q26b. Where were you chased? .....[26b]_____

Q26c. When was the last time you were chased? .....[26c]_____

Q27a. How many times have you *seen* someone else get chased by gangs or older kids? ..... [27a] _____

Q27b. Who did this happen to? (What was the person's relationship to you?) [27b]_____

Q27c. Where did you see this happen? .....[27c]_____

Q27d. When was the last time you *saw* someone being chased? [27d]_____

Q28a. How many times have you only *heard* about someone being chased by gangs or older kids? ..... [28a] _____

Q28b. Who was being chased? .....[28b]_____

Q28c. Who did the chasing? .....[28c]_____

Q28d. Where were they being chased? .....[28d]_____

Q28e. When was the last time you *heard* of this happening? ...[28e]_____

DRUGS

Q29a. How many times have you *seen* other people *using or selling* illegal drugs? [29a]_____

Q29b. Who was using or selling drugs? .....[29b]_____

Q29c. Where did you see this happen? .....[29c]_____

Q29d. When was the last time you *saw* this? .....[29d]_____

Q30a. How many times have *you yourself* actually been asked to get involved in any aspect of *selling or distributing* illegal drugs? .....[30a]_____

Q30b. Who asked? .....[30b]_____

Q30c. Where did it happen? .....[30c]_____

Q30d. When was the last time it happened? .....[30d]_____

Q31a. How many times have *you yourself* actually been asked to *use* illegal drugs? .....[31a]_____

Q31b. Who asked? .....[31b]_____

Q31c. Where did it happen? .....[31c]_____

Q31d. When was the last time it happened? .....[31d]_____

Q32a. How many times have you *seen* someone else being asked to get involved in any aspect of *selling or distributing* illegal drugs? .....[32a]_____

Q32b. Who was asked? .....[32b]_____

Q32c. Who did the asking? .....[32c]_____

Q32d. Where were they when they were asked? .....[32d]_____

Q32e. When was the last time you *saw* this happen? .....[32e]_____

Q33a. How many times have you only *heard* about someone else being asked to get involved in any aspect of selling or distributing illegal drugs? .....[33a]_____

Q33b. Who was being asked? .....[33b]_____

Q33c. Who did the asking? .....[33c]_____

Q33d. Where were they when they were asked? .....[33d]_____

Q33e. When was the last time you heard of this happening? ...[33e]_____

SERIOUS ACCIDENTS

Q34a. How many times have *you yourself* actually been in a serious accident where you thought that you or someone else would get hurt very badly or die? .....[34a]_____

Q34b. Where did this happen? .....[34b]_____

Q34c. When was the last time this happened? .....[34c]_____

Q35a. How many times have you *seen* someone else have a serious accident where you thought that the person would get hurt very badly or die? .....[35a]_____

Q35b. Who was in the accident? .....[35b]_____

Q35c. Where did you see this happen? .....[35c]_____

Q35d. When was the last time you *saw* this happen? .....[35d]_____

Q36a. How many times have you only *heard* about someone else having a serious accident where you thought the person could have been very badly hurt or died? .....[36a]_____

Q36b. Who was in the accident? .....[36b]_____

Q36c. Where did the accident happen? .....[36c]_____

Q36d. When was the last time you heard of such an accident? .[36d]_____

PEOPLE BREAKING INTO HOUSES

Q37a. How many times have *you yourself* actually been at home when someone has broken into or tried to force their way into your home? .....[37a]_____

Q37b. Who broke into the house? .....[37b]_____
Q37c. When was the last time this happened? .....[37c]_____

Q38a. How many times has your house been broken into when you weren't home? [38a]_____
Q38b. Who broke into the house? .....[38b]_____
Q38c. When was the last time this happened? .....[38c]_____

Q39a. How many times have you *seen* someone trying to force their way into somebody else's house or apartment? .....[39a]_____
Q39b. Who did this happen to? .....[39b]_____
Q39c. Who tried to break into the house? .....[39c]_____
Q39d. Where did it happen? .....[39d]_____
Q39e. When was the last time this happened? .....[39e]_____

Q40a. How many times have you only *heard* about someone trying to force their way into somebody else's house or apartment? .....[40a]_____
Q40b. Whose house was broken into? .....[40b]_____
Q40c. Who tried to break into the house? .....[40c]_____
Q40d. When was the last time you *heard* of this happening? .....[40d]_____

PEOPLE GETTING ARRESTED
Q41a. How many times have *you yourself* actually been picked-up, arrested, or taken away by the police? .....[41a]_____
Q41b. Where were you when this happened? .....[41b]_____
Q41c. When was the last time this happened? .....[41c]_____

Q42a. How many times have you *seen* someone else being picked-up, arrested, or taken away by the police? .....[42a]_____
Q42b. Who did this happen to? .....[42b]_____
Q42c. Where did this happen? .....[42c]_____
Q42d. When was the last time you *saw* this happen? .....[42d]_____

Q43a. How many times have you only *heard* about someone else being picked-up, arrested,
or taken away by the police? .....[43a]_____
Q43b. Who did this happen to? .....[43b]_____
Q43c. Where did this happen? .....[43c]_____
Q43d. When was the last time you *heard* about this happening? [43d]_____

These next questions ask you about **THREATS** you may have experienced, seen, or heard about.

Q44a. How many times have *you yourself* actually been threatened with serious

physical harm by someone? .....[44a]_____

Q44b. Who did the threatening? .....[44b]_____

Q44c. Where did this happen? .....[44c]_____

Q44d. When was the last time this happened? .....[44d]_____

Q45a. How many times have you *seen* someone else being threatened with serious physical harm? .....[45a]_____

Q45b. Who was threatened? .....[45b]_____

Q45c. Who did the threatening? .....[45c]_____

Q45d. Where were they when they were threatened? .....[45d]_____

Q45e. When was the last time you *saw* this happen? .....[45e]_____

Q46a. How many times have you only *heard* about someone else being threatened with serious physical harm? .....[46a]_____

Q46b. Who was threatened? .....[46b]_____

Q46c. Who did the threatening? .....[46c]_____

Q46d. Where did the threat take place? .....[46d]_____

Q46e. When was the last time you *heard* of this happening? .....[46e]_____

SLAPPING, HITTING, AND PUNCHING

Q47a. How many times have *you yourself* actually been slapped, punched, or hit by someone? .....[47a]_____

Q47b. Who did this? .....[47b]_____

Q47c. Where did this happen? .....[47c]_____

Q47d. When was the last time this happened? .....[47d]_____

Q48a. How many times have you *seen* someone else being slapped, punched, or hit by a *member of their family*? .....[48a]_____

Q48b. Who did this happen to? .....[48b]_____

Q48c. Which one of this person's family members did this?

1. Parent(s) 2. Brother/Sister 3. Other Relative 4. Don't Know

.....[48c]_____

Q48d. Where did it happen? .....[48d]_____

Q48e. When was the last time you *saw* this happen? .....[48e]_____

Q49a. How many times have you only *heard* about someone else being slapped, punched, or hit by a member of their family? .....[49a]_____

Q49b. Who did this happen to? .....[49b]_____

Q49c. Which one of this person's family members did this?

1. Parent(s) 2. Brother/Sister 3. Other Relative 4. Don't Know

.....[49c]_____

Q49d. Where did it happen? .....[49d]_____

Q49e. When was the last time you *heard* about this happening? ...[49e]_____

Q50a. How many times have you *seen* another person being slapped, punched, or hit by someone who was *NOT* a member of their family? .....[50a]_____

Q50b. Who did this happen to? .....[50b]_____

Q50c. Who did it? .....[50c]_____

Q50d. Where did it happen? .....[50d]_____

Q50e. When was the last time you *saw* this happen? .....[50e]_____

Q51a. How many times have you only *heard* about someone else getting slapped, punched, or hit by a person who was *NOT* a member of their family? .....[51a]_____

Q51b. Who did this happen to? .....[51b]_____

Q51c. Who did it? .....[51c]_____

Q51d. Where did it happen? .....[51d]_____

Q51e. When was the last time you *heard* of this happening? .....[51e]_____

BEATINGS AND MUGGINGS

Q52a. How many times have *you yourself* actually been beaten up or mugged? .....[52a]_____

Q52b. Who did the beating up or mugging? .....[52b]_____

Q52c. Where did the beating up or mugging happen? .....[52c]_____

Q52d. When was the last time this happened? .....[52d]_____

Q53a. How many times have you *seen* someone else getting beaten up or mugged? .....[53a]_____

Q53b. Who was beaten up or mugged? .....[53b]_____

Q53c. Who did the beating up or mugging? .....[53c]_____

Q53d. Where did you see the beating up or mugging? .....[53d]_____

Q53e. When was the last time you *saw* this happen? .....[53e]_____

Q54a. How many times have you only *heard* about someone else being beaten up or mugged? .....[54a]_____

Q54b. Who was beaten up or mugged? .....[54b]_____

Q54c. Who did the beating up or mugging? .....[54c]_____

Q54d. Where did the beating up or mugging happen? .....[54d]_____

Q54e. When was the last time you *heard* of this happening? .....[54e]_____

CARRYING GUNS AND KNIVES

Q55a. How many times have you actually *seen* someone carrying or holding a gun or knife? (do not include police, military, or security officers) .....[55a]_____

Q55b. Who had the weapon? .....[55b]_____

Q55c. Where did you see this? .....[55c]_____

Q55d. When was the last time you *saw* someone carrying or holding a weapon? .....[55d]_____

Q56a. How many times have you only *heard* about someone carrying a gun or knife? .....[56a]_____

Q56b. Who had the weapon? .....[56b]_____

Q56c. Where was the person carrying or holding the weapon?.....[56c]_____

Q56d. When was the last time you heard of this happening? .....[56d]_____

Q57a. How many times have *you yourself* heard the sound of gunfire outside when you were in or near your home? .....[57a]_____

Q57b. How many times have *you yourself* heard the sound of gunfire outside when in or near the school building? .....[57b]_____

[ASK Q57c if YES to Q57a. **OR** Q57b. above.]

Q57c. When was the last time you heard gunfire near home or school? .....[57c]_____

Q58a. How many times have you seen or heard a gun fired *in your home*? ....[58a]_____

Q58b. Who shot the gun? .....[58b]_____

Q58c. Why was the gun fired?

1. Argument 2. Accidental Discharge 3. Other (specify below)

.....[58c]_____

PEOPLE WHO HAVE BEEN SERIOUSLY WOUNDED

Q59a. How many times have you actually *seen* a seriously wounded person after an incident of violence? .....[59a]_____

Q59b. Who was wounded? .....[59b]_____

Q59c. Where did you see this? .....[59c]_____

Q59d. When was the last time you *saw* this? .....[59d]_____

Q60a. How many times have you only *heard* about a person seriously wounded after an incident of violence? .....[60a]_____

Q60b. Who was wounded? .....[60b]_____

Q60c. Where did this happen? .....[60c]_____

Q60d. When was the last time you heard about this? .....[60d]_____

KNIFE ATTACKS

Q61a. How many times have *you yourself* actually been attacked or stabbed with a knife? .....[61a]_____

Q61b. Who was the attacker? .....[61b]_____

Q61c. Where did it happen? .....[61c]_____

Q61d. When was the last time this happened? .....[61d]_____

Q62a. How often have you *seen* someone else being attacked or stabbed with a knife? .....[62a]_____

Q62b. Who was attacked? .....[62b]_____

Q62c. Who did the attacking? .....[62c]_____

Q62d. Where did it happen? .....[62d]_____
Q62e. When was the last time this happened? .....[62e]_____

Q63a. How many times have you only *heard* about someone else being attacked or stabbed with a knife? .....[63a]_____
Q63b. Who was attacked? .....[63b]_____
Q63c. Who did the attacking? .....[63c]_____
Q63d. Where did it happen? .....[63d]_____
Q63e. When was the last time you *heard* of this happening? ...[63e]_____

SHOOTINGS

Q64a. How many times have *you yourself* actually been shot with a gun? .....[64a]_____
0. Never 1. Once 2. Twice 3. 3 or 4 Times 4. 5 or More Times
Q64b. Where did it happen? .....[64b]_____
Q64c. Who did the shooting? .....[64c]_____
Q64d. When was the last time this happened? .....[64d]_____

Q65a. How often have you *seen* someone else get shot with a gun? .....[65a]_____
0. Never 1. Once 2. Twice 3. 3 or 4 Times 4. 5 or More Times
Q65b. Who got shot? .....[65b]_____
Q65c. Who did the shooting? .....[65c]_____
Q65d. Where did it happen? .....[65d]_____
Q65e. When was the last time this happened? .....[65e]_____

Q66a. How many times have you only *heard* about someone else getting shot with a gun? .....[66a] _____
0. Never 1. Once 2. Twice 3. 3 or 4 Times 4. 5 or More Times
Q66b. Who got shot? .....[66b]_____
Q66c. Who did the shooting? .....[66c]_____
Q66d. Where did it happen? .....[66d]_____
Q66e. When was the last time you *heard* of this happening?.....[66e]_____

DEAD BODIES

Q67a. How many times have you actually *seen* a dead person somewhere in the community? (do not include wakes and funerals) .....[67a]_____
0. Never 1. Once 2. Twice 3. 3 or 4 Times 4. 5 or More Times
Q67b. Who was the dead person? .....[67b]_____
Q67c. Where did you see this? .....[67c]_____
Q67d. When was the last time you saw this? .....[67d]_____

Q68a. How many times have you only *heard* about a dead body somewhere in the community? (do not include wakes and funerals) ..... [68a]_____
0. Never 1. Once 2. Twice 3. 3 or 4 Times 4. 5 or More Times
Q68b. Who was the dead person? .....[68b]_____

Q68c. Who saw the dead person? .....[68c]_____
Q68d. Where was the dead person seen? .....[68d]_____
Q68e. When was the last time you *heard* about someone seeing a dead body?
.....[68e]_____

SUICIDES AND KILLINGS

Q69a. How many times have you actually *seen* someone attempting suicide? ..[69a]_____
0. Never 1. Once 2. Twice 3. 3 or 4 Times 4. 5 or More Times
Q69b. Who attempted suicide? .....[69b]_____
Q69c. Where did you see this happen? .....[69c]_____
Q69d. When was the last time you saw this? .....[69d]_____

Q70a. How many times have you only *heard* about someone attempting suicide?
.....[70a]_____
0. Never 1. Once 2. Twice 3. 3 or 4 Times 4. 5 or More Times
Q70b. Who attempted suicide? .....[70b]_____
Q70c. Where did the suicide take place? .....[70c]_____
Q70d. When was the last time you *heard* about someone attempting suicide?
.....[70d]_____

Q71a. How many times have you actually *seen* someone being killed by another person? .....[71a]_____
0. Never 1. Once 2. Twice 3. 3 or 4 Times 4. 5 or More Times
Q71b. Who got killed? .....[71b]_____
Q71c. Who did the killing? .....[71c]_____
Q71d. Where did you see the killing? .....[71d]_____
Q71e. When was the last time you saw someone being killed? ...[71e]_____

Q72a. How many times have you only *heard* about someone being killed by another person? .....[72a]_____
0. Never 1. Once 2. Twice 3. 3 or 4 Times 4. 5 or More Times
Q72b. Who got killed? .....[72b]_____
Q72c. Who did the killing? .....[72c]_____
Q72d. Where did the killing take place? .....[72d]_____
Q72e. When was the last time you *heard* about someone being killed? [72e]_____

Q73a. How many times have you been in any kind of situation not already described where you were extremely frightened or thought that you would get hurt very badly or die? Describe that situation in your own words. [record description in space below]
.....[73a]_____

Q73b. Where did this happen? .....[73b]_____
Q73c. When was the last time something like this happened.....[73c]_____

APPENDIX 1C:

TRAUMA SYMPTOM CHECKLIST FOR CHILDREN

Q74. Next I am going to ask you several questions about your thoughts and feelings about the violence you may have seen or experienced. Please think about what you have been thinking and feeling **during the past 2 weeks**. For each question, respond on the following scale:

1. Never 2. Sometimes 3. Lots of Times 4. Almost All of the Time

	[1]	[2]	[3]	[4]
How much of these have you experienced ***in the last 2 weeks***?	Never	Sometimes	Lots of Times	Almost All of the Time
1. Bad dreams or nightmares	1	2	3	4
2. Feeling afraid something bad might happen	1	2	3	4
3. Scary ideas or pictures just pop into my head	1	2	3	4
4. Pretending I am someone else	1	2	3	4
5. Arguing too much	1	2	3	4
6. Feeling sad or unhappy	1	2	3	4
7. Remembering things that happened that I didn't like	1	2	3	4
8. Going away in my mind, trying not to think	1	2	3	4
9. Remembering scary things	1	2	3	4
10. Getting scared all of a sudden and don't know why	1	2	3	4
11. Feeling dizzy	1	2	3	4
12. Wanting to yell at people	1	2	3	4
13. Feeling scared of men	1	2	3	4
14. Feeling scared of women	1	2	3	4

How much of these have you experienced *in the last 2 weeks*?	Never	Sometimes	Lots of Times	Almost All of the Time
15. Washing myself because I feel dirty on the inside	1	2	3	4
16. Feeling stupid or bad	1	2	3	4
17. Feeling like I did something wrong	1	2	3	4
18. Feeling like things aren't real	1	2	3	4
19. Forgetting things, can't remember things	1	2	3	4
20. Feeling like I'm not in my body	1	2	3	4
21. Feeling nervous or jumpy inside	1	2	3	4
22. Feeling afraid	1	2	3	4
23. Can't stop thinking about something bad that happened to me	1	2	3	4
24. Pretending I'm somewhere else	1	2	3	4
25. Being afraid of the dark	1	2	3	4
26. Worrying about things	1	2	3	4
27. Remembering things I don't want to remember	1	2	3	4
28. My mind going empty or blank	1	2	3	4
29. Trying not to have any feelings	1	2	3	4
30. Feeling mad	1	2	3	4
31. Feeling afraid somebody will kill me	1	2	3	4
32. Wishing bad things had never happened	1	2	3	4
33. Daydreaming	1	2	3	4

APPENDIX 1D:

FAMILY ALCOHOL AND DRUG SURVEY (FADS)

I. Introduction

a. Remind respondent that all information will be kept confidential.
b. We will be asking you about alcohol and drug use in *biological* relatives of (*child*).

II. Construct "Family Tree" or Genogram (draw in aunts and uncles)

III. Explain TYPES

a. Everyone has different definitions for problem drinking, heavy drinking, etc. So, to help us be sure that everyone is using the same system, we have some categories and are asking you to classify people by "TYPES."
b. We are asking about people's *heaviest use EVER*.
c. Review handout for: 1) Alcohol TYPE A, 2) Problems, 3) Alcohol TYPES B-E
d. Define "drugs" (illegal drugs, other substances like glue, abuse of prescriptions, etc.)
e. Review handout for: 1) Drug TYPEA, 2) Problems, 3) Drug TYPES B-E

IV. Questions:

** Ask all questions for all but top row (grandparents). For those distant relatives, do not ask if living, age, or onset for TYPE A. **

a. Alive? If so, record age. If not, record how they died and age at death.
b. Alcohol TYPE
   i. If report TYPE A, confirm problems and record age of onset of **first use** (**AO**=).
   ii. If unsure of TYPE, probe for **NP** (no problem). If still don't know, label as **DK**.
c. Drug TYPE
   i. If report TYPEA, confirm problems and record age of onset of **first use** (**DO**=).
   ii. If unsure of TYPE, probe for **NP** (no problem). If still don't know, label as **DK**.

V. Order of Relatives If Interviewing *(child's)* Biological Mother

a. Mother's Biological Father
b. Mother's Biological Mother
c. Mother's Siblings
d. Biological Mother (respondent)
e. Mother's Paternal Grandparents

f. Mother's Maternal Grandparents
g. (child's) Biological Father
h. Biological Father's Siblings
i. Father's Parents
j. Father's Paternal Grandparents
k. Father's Maternal Grandparents

VI. Order of Relatives If Interviewing *(child's)* Grandmother or Great Grandmother

(START ON HER SIDE OF FAMILY TREE)
a. (child's) Great Grandfather
b. (child's) Great Grandmother (if interviewing great grandmother, this is self)
c. (child's) Grandfather
d. (child's) Grandmother (if interviewing grandmother, this is self)
e. (child's) Parent
f. (child's) Parent's Siblings / (child's) Aunts and Uncles
g. Other set of Great Grandparents

(BEGINNING ON OTHER SIDE OF FAMILY TREE)
h. (child's) other Parent
i. (child's) Parent's Siblings / (child's) other Aunts and Uncles
j. Other set of Grandparents
k. Other sets of Great Grandparents (Paternal, then Maternal)

VII. Order of Relatives If Interviewing Aunt

(START ON HER SIDE OF FAMILY TREE)
a. (her) Father / (child's) Grandfather
b. (her) Mother / (child's) Grandmother
c. (her) Siblings / (child's) Aunts, Uncles, and Parent
d. Herself
e. (child's) Great Grandparents (Paternal, then Maternal)

(BEGINNING ON OTHER SIDE OF FAMILY TREE)
f. (child's) other Parent
g. (child's) Parent's Siblings / (child's) other Aunts and Uncles
h. (child's) other Grandparents
i. (child's) other Great Grandparents (Paternal, then Maternal)

VIII. Order of Relatives If Interviewing a Non-Biological Caregiver
a. (child's) Mother, Aunts/Uncles, Grandparents, Great Grandparents
b. (child's) Father, Aunts/Uncles, Grandparents, Great Grandparents

Alcohol Drinking Patterns

For each family member, what has been his/her
HEAVIEST pattern of use **EVER**?

TYPE A Drank *heavily*, *often* becoming intoxicated when drinking,
AND

had significant problems caused by drinking

[Review TYPE A Problems]

TYPE B Drank *heavily*, *often* becoming intoxicated when drinking, but did

NOT have significant problems caused by drinking

TYPE C Drank *regularly*, *normally* did not become intoxicated when drinking, and did NOT have significant problems caused by drinking (social drinking)

TYPE D Drank *rarely*, *never* became intoxicated when drinking, and did NOT have significant problems caused by drinking (for example, a drink at holidays, weddings, or special occasions)

TYPE E *Never* drank alcohol (or never completed a full drink of alcohol)

"TYPE A" Alcohol Drinking Problems

- **FAMILY PROBLEMS:** Examples include fights or problems with husband/wife/child or other relative(s) due to the person's drinking.

- **SOCIAL PROBLEMS:** Examples include arguments or difficulties with friends or other acquaintances due to the person's drinking.

- **JOB OR SCHOOL PROBLEMS:** Examples include poor job performance, missed work or classes, or being fired due to the person's drinking.

- **FINANCIAL PROBLEMS:** Examples include difficulty paying bills, buying groceries or necessities, or financial difficulties leading to problems in other areas (i.e., family, social, school) due to the person's drinking.

- **LEGAL PROBLEMS:** Examples include more than one DWI, other traffic arrests, or police problems due to the person's drinking.

- **HEALTH PROBLEMS:** Examples include liver damage, stomach pains, or heart/blood pressure problems due to the person's drinking.

- **TREATMENT FOR ALCOHOL ABUSE:** Examples include inpatient/ residential treatment, outpatient treatment, or regular AA attendance by the person.

Drug Use Patterns

For each family member, what has been his/her
HEAVIEST pattern of drug or substance use **EVER**?

TYPE A Used *heavily* AND had significant problems caused by drug use

[Review TYPE A Problems]

TYPE B Used *heavily* but did NOT have significant problems caused by drug use

TYPE C Used *regularly* and did NOT have significant problems caused by

drug use (social or recreational use)

TYPE D Used *rarely* and did NOT have significant problems caused by drug use (experimental use)

TYPE E *Never* used illicit drugs

Drug Or Substance Use Includes:

- **illegal drugs**
- **legal substances used for the purpose of getting high**
- **prescription drugs**
  - **--without a doctor's prescription**
  - **--in greater amounts than prescribed**
  - **--more often than prescribed**
  - **--for any reasons other than a doctor said they should be taken**

"TYPE A" Drug Problems

- **FAMILY PROBLEMS:** Examples include fights or problems with husband/wife/child or other relative(s) due to the person's drug use.

- **SOCIAL PROBLEMS:** Examples include arguments or difficulties with friends or other acquaintances due to the person's drug use.

- **JOB OR SCHOOL PROBLEMS:** Examples include poor job performance, missed work or classes, or being fired due to the person's drug use.

- **FINANCIAL PROBLEMS:** Examples include difficulty paying bills, buying groceries or necessities, or financial difficulties leading to problems in other areas (i.e., family, social, school) due to the person's drug use.

- **LEGAL PROBLEMS:** Examples include traffic arrests or police problems due to the person's drug use.

- **HEALTH PROBLEMS:** Examples include infections, stomach pains, or heart/blood pressure problems due to the person's drug use.

- **TREATMENT FOR DRUG ABUSE:** Examples include inpatient/ residential treatment, outpatient treatment, or regular NA attendance by the person.

APPENDIX 1E:

CHILD REPORT OF PARENT BEHAVIOR INVENTORY (CRPIBI)

Q-7 The first set of questions has to do with your caregiver – the person we are interviewing today. These questions ask about how she is involved in your day-to-day living. For each statement, please circle whether you feel that she is
A Lot Like, ***Somewhat Like***, or ***Not Like*** the following.

	[1]	[2]	[3]
	A Lot Like	**Somewhat Like**	**Not Like**
1. Makes you feel better after talking over your worries with her.	**1**	**2**	**3**
2. Is NOT very patient with you.	**1**	**2**	**3**
3. Thinks your ideas are silly.	**1**	**2**	**3**
4. Understands your problems and your worries.	**1**	**2**	**3**
5. Forgets to help you when you need help.	**1**	**2**	**3**
6. Smiles at you very often.	**1**	**2**	**3**
7. Always getting after you (or nagging you about something).	**1**	**2**	**3**
8. Acts as though you are in the way.	**1**	**2**	**3**
9. Almost always complains about what you do.	**1**	**2**	**3**
10. Enjoys doing things with you.	**1**	**2**	**3**
11. Enjoys working with you in the house or yard.	**1**	**2**	**3**
12. Often blows her top when you bother her.	**1**	**2**	**3**
13. Comforts you when you are afraid.	**1**	**2**	**3**
14. Cheers you up when you are sad.	**1**	**2**	**3**
15. Does not get you things unless you ask for them over and over again.	**1**	**2**	**3**
16. Does NOT seem to know what you need or want.	**1**	**2**	**3**
17. Has a good time at home with you.	**1**	**2**	**3**
18. Does NOT work with you.	**1**	**2**	**3**
19. Seems proud of the things you do.	**1**	**2**	**3**
20. Is able to make you feel better when you are upset.	**1**	**2**	**3**

APPENDIX 1F:

NETWORK OF RELATIONSHIPS INVENTORY - REVISED (NRI-R)

Q-81 In this next section we want to get your ideas on some people in your family and some of your friends. Please answer these questions in a way that lets us know how you felt about these people ***over the past 6 MONTHS***. Circle the number that best describes how you have felt.

The first questions are about the person we are interviewing with you today, who we will call "MOM."

	[1] **Little or None**	[2] **Somewhat**	[3] **Very Much**	[4] **Extremely Much**	[5] **The Most Possible**
1. How much can you count on MOM to be there when you need her no matter what?	**1**	**2**	**3**	**4**	**5**
2. How much can you rely on MOM to really care about you without this changing from time to time?	**1**	**2**	**3**	**4**	**5**
3. How much does MOM treat you like you're admired and respected?	**1**	**2**	**3**	**4**	**5**
4. How much does MOM give you good advice about how to handle problems you have?	**1**	**2**	**3**	**4**	**5**
5. How often do you do enjoyable things with MOM?	**1**	**2**	**3**	**4**	**5**
6. How much does MOM really care about you?	**1**	**2**	**3**	**4**	**5**
7. How much do you share your private feelings with MOM?	**1**	**2**	**3**	**4**	**5**
8. How much do you have conflicts with MOM that make you feel angry or upset?	**1**	**2**	**3**	**4**	**5**

APPENDIX 1G:

PARENTING PRACTICES SCALE

Q83. The next questions are about you and your parent(s).

	[1]	[2]	[3]	[4]	[5]
1. Do your parents know what you do during your free time?	Almost Always	Usually	It Depends	Seldom	Never
2. Do your parents know the friends you hang out with during your free time?	Know All of Them	Know Most of Them	Know Several of Them	Know a Couple of Them	Know None of Them
3. Do your parents usually know what type of homework you have?	Almost Always	Usually	It Varies	Seldom	Never
4. Do your parents know what you spend your money on?	Almost Always	Usually	It Varies	Seldom	Never
5. Do your parents usually know when you have an exam or paper due at school?	Almost Always	Usually	It Varies	Seldom	Never
6. Do your parents know how you do in different subjects at school?	Yes, Completely	Yes, the Majority	Yes, Partly	No, Very Little	No, Nothing
7. Do your parents know where you go when you are out with friends at night?	Yes, Always	Yes, Usually	Sometimes	No, Not Often	No, Never
8. Do your parents normally know where you go and what you do after school?	Yes, Everything	Yes, Mostly	Partly	No, Very Little	No, Nothing
9. In the last month, have your parents ever had no idea of where you were at night?	Never	A Few Rare Times	Several Times	Many Times	Most of the time
10. Do you talk at home with your parents about how you are doing in the different subjects in school?	Tell Almost Everything	Tell A Lot	Tell Some Things	Keep A Lot To Myself	Keep Almost Everything to Myself
11. Do you usually tell your parents how school was when you get home	A Lot	Very Often	Occasionally	Seldom	Almost Never

(how you did on different exams, your relationships with teachers, etc.)?					
12. Do you keep a lot of secrets from your parents about what you do during your free time?	A Lot	Very Much	Some Parts	Just a Little	Not at All
13. Do you hide a lot from your parents about what you do during nights and weekends?	A Lot	Very Much	Some Parts	Just a Little	Not at All
14. If you are out at night, when you get home, do you tell what you have done that evening?	Most of the Time	Often	Sometimes	More Seldom	Almost Never
15. In the last month, have your parents talked with the parents of your friends?	Several Times a Week	At Least Once a Week	A Few Times This Month	Once or Twice This Month	Not at All This Month
16. How often do your parents talk with your friends when they come to your home (ask what they do or what they think and feel about different things)?	Almost Always	Often	Sometimes	Seldom	Almost Never
17. During the past month, how often have your parents started a conversation with you about your free time?	Several Times a Week	At Least Once a Week	A Few Times This Month	Once or Twice This Month	Not at All This Month
18. How often do your parents initiate a conversation about things that happened during a normal day at school?	A Lot	Often	Occasionally	Seldom	Almost Never
19. Do your parents usually ask you to talk about things that happened during your free time (whom you met when you were out in the city, free time activities...)?	A Lot	Often	Occasionally	Seldom	Almost Never
20. Do you need to have your parents' permission to stay out late on a weekday evening?	Yes, Always	Yes, Usually	Yes, Sometimes	No, Seldom	No, Never

21. Do you need to ask your parents before you can decide with your friends what you will do on a Saturday evening?	Yes, Always	Yes, Usually	Yes, Sometimes	No, Seldom	No, Never
22. If you have been out very late one night, do your parents require that you explain what you did and whom you were with?	Yes, Always	Yes, Usually	Yes, Sometimes	No, Seldom	No, Never
23. Do your parents always require that you tell them where you are at night, who you are with, and what you do together?	Yes, Always	Yes, Usually	Yes, Sometimes	No, Seldom	No, Never
24. Before you go out on a Saturday night, do your parents require you to tell them where you are going and with whom?	Yes, Always	Yes, Usually	Yes, Sometimes	No, Seldom	No, Never

Q29. **The next questions ask about you and (*child*). [confirm response choice for each question]**

	[1]	[2]	[3]	[4]	[5]
1. Do you know what *(child)* does during his/her free time?	Almost Always	Usually	It Depends	Seldom	Never
2. Do you know which friends *(child)* hangs out with during his/her free time?	Know All of Them	Know Most of Them	Know Several of Them	Know a Couple of Them	Know None of Them
3. Do you usually know what type of homework *(child)* has?	Almost Always	Usually	It Varies	Seldom	Never
4. Do you know what *(child)* spends his/her money on?	Almost Always	Usually	It Varies	Seldom	Never
5. Do you know when *(child)* has an exam or paper due at school?	Almost Always	Usually	It Varies	Seldom	Never
6. Do you know how *(child)* does in different subjects at school?	Yes, Com-pletely	Yes, the Majority	Yes, Partly	No, Very Little	No, Nothing
7. Do you know where *(child)* goes when s/he is out with friends at night?	Yes, Always	Yes, Usually	Some-times	No, Not Often	No, Never
8. Do you normally know where *(child)*	Yes, Every-	Yes, Mostly	Partly	No, Very Little	No, Nothing

21. Do you need to ask your parents before you can decide with your friends what you will do on a Saturday evening?	Yes, Always	Yes, Usually	Yes, Sometimes	No, Seldom	No, Never
22. If you have been out very late one night, do your parents require that you explain what you did and whom you were with?	Yes, Always	Yes, Usually	Yes, Sometimes	No, Seldom	No, Never
23. Do your parents always require that you tell them where you are at night, who you are with, and what you do together?	Yes, Always	Yes, Usually	Yes, Sometimes	No, Seldom	No, Never
24. Before you go out on a Saturday night, do your parents require you to tell them where you are going and with whom?	Yes, Always	Yes, Usually	Yes, Sometimes	No, Seldom	No, Never

Q29. **The next questions ask about you and (*child*). [confirm response choice for each question]**

	[1]	[2]	[3]	[4]	[5]
1. Do you know what *(child)* does during his/her free time?	Almost Always	Usually	It Depends	Seldom	Never
2. Do you know which friends *(child)* hangs out with during his/her free time?	Know All of Them	Know Most of Them	Know Several of Them	Know a Couple of Them	Know None of Them
3. Do you usually know what type of homework *(child)* has?	Almost Always	Usually	It Varies	Seldom	Never
4. Do you know what *(child)* spends his/her money on?	Almost Always	Usually	It Varies	Seldom	Never
5. Do you know when *(child)* has an exam or paper due at school?	Almost Always	Usually	It Varies	Seldom	Never
6. Do you know how *(child)* does in different subjects at school?	Yes, Com-pletely	Yes, the Majority	Yes, Partly	No, Very Little	No, Nothing
7. Do you know where *(child)* goes when s/he is out with friends at night?	Yes, Always	Yes, Usually	Some-times	No, Not Often	No, Never
8. Do you normally know where *(child)*	Yes, Every-	Yes, Mostly	Partly	No, Very Little	No, Nothing

20. Does *(child)* need to have your permission to stay out late on a weekday evening?	Yes, Always	Yes, Usually	Yes, Some-times	No, Seldom	No, Never
21. Does *(child)* need to ask you before deciding with his/her friends what they will do on a weekend evening?	Yes, Always	Yes, Usually	Yes, Some-times	No, Seldom	No, Never
22. If *(child)* has been out very late one night, do you require that s/he explain what s/he did and who s/he was with?	Yes, Always	Yes, Usually	Yes, Some-times	No, Seldom	No, Never
23. Do you require that *(child)* tell you where s/he is at night, who s/he is with, and what they do together?	Yes, Always	Yes, Usually	Yes, Some-times	No, Seldom	No, Never
24. Before *(child)* goes out on a weekend night, do you require *(child)* to tell you where s/he is going and with whom?	Yes, Always	Yes, Usually	Yes, Some-times	No, Seldom	No, Never

APPENDIX 1H:

TORONTO ALEXITHYMIA SCALE-20 (TAS-20)

Q41. Please choose the number that best describes how the following statements describe you, using the following scale:

1. Not At All Like Me, or Not True
2. A Little Like Me, or A Little True
3. Somewhat Like Me, or Sometimes True
4. Quite A Bit Like Me, or Pretty True
5. Completely Like Me, or Very True

	[1]	[2]	[3]	[4]	[5]
How well does this describe you . . .	Not At All Like Me/ Not True	A Little Like Me/A Little True	Somewhat Like Me/ Some-times True	Quite A Bit Like Me/ Pretty True	Completely Like Me/ Very True
1. I am often confused about what emotion I am feeling.	1	2	3	4	5
2. It is difficult for me to find the right words for my feelings.	1	2	3	4	5
3. I have physical sensations that even doctors don't understand.	1	2	3	4	5
4. I am able to describe my feelings easily.	1	2	3	4	5
5. I prefer to analyze problems rather than just describe them.	1	2	3	4	5
6. When I am upset, I don't know if I am sad, frightened, or angry.	1	2	3	4	5
7. I am often puzzled by sensations in my body.	1	2	3	4	5
8. I prefer to just let things happen rather than to understand why they turned out that way.	1	2	3	4	5
9. I have feelings that I can't quite identify.	1	2	3	4	5
10. Being in touch with emotions is essential.	1	2	3	4	5
11. I find it hard to describe how I feel about people.	1	2	3	4	5
12. People tell me to describe my feelings more.	1	2	3	4	5

13. I don't know what's going on inside me.	1	2	3	4	5
14. I often don't know why I am angry.	1	2	3	4	5
15. I prefer talking to people about their *daily* ***activities*** rather than their ***feelings.***	1	2	3	4	5
16. I prefer to watch "light" entertainment shows rather than psychological dramas.	1	2	3	4	5
17. It is difficult for me to reveal my innermost feelings, even to close friends.	1	2	3	4	5
18. I can feel close to someone, even in moments of silence.	1	2	3	4	5
19. I find examination of my feelings useful in solving personal problems.	1	2	3	4	5
20. Looking for hidden meanings in movies or plays distracts from their enjoyment.	1	2	3	4	5

APPENDIX 1I:

COPE

Q31. Now we are going to shift gears and talk about ***you***. First we'd like to know a bit about how ***you*** normally handle violence that you have ***experienced, seen, or heard about***. Please do ***not*** include things you may have seen or heard about only on TV, radio, the news, or in the movies. For each question I read, please tell me:

1. I Don't Do This At All 2. I Do This A Little Bit 3. I Do This A Medium Amount
4. I Do This A Lot

	[1]	[2]	[3]	[4]
As a result of violence you have experienced, seen or heard about . . how much do you . . .	I Don't Do This At All	I Do This A Little Bit	I Do This A Medium Amount	I Do This A Lot
1. I try to grow as a person as a result of the experience.	1	2	3	4
2. I turn to work or other substitute activities to take my mind off things.	1	2	3	4
As a result of violence you have experienced, seen or heard about . . how much do you . . .	I Don't Do This At All	I Do This A Little Bit	I Do This A Medium Amount	I Do This A Lot
3. I get upset and let my emotions run out.	1	2	3	4
4. I try to get advice from someone about what to do.	1	2	3	4
5. I concentrate my efforts on doing something about it.	1	2	3	4
6. I say to myself "this isn't real."	1	2	3	4
7. I put my trust in God.	1	2	3	4
8. I admit to myself that I can't deal with it and quit trying.	1	2	3	4
9. I discuss my feelings with someone else.	1	2	3	4
10. I use alcohol or drugs to make myself feel better.	1	2	3	4
11. I talk to someone to find out more about the situation.	1	2	3	4
12. I daydream about things other than the problem.	1	2	3	4

13. I get upset and am really aware of it.	1	2	3	4
14. I seek God's help.	1	2	3	4
15. I make a plan of action.	1	2	3	4
16. I try to get emotional support from friends or relatives.	1	2	3	4
17. I just give up trying to reach my goal.	1	2	3	4
18. I take additional action to try to get rid of the problem.	1	2	3	4
19. I try to lose myself for a while by drinking or taking drugs.	1	2	3	4
20. I refuse to believe that it has happened.	1	2	3	4
21. I let my feelings out.	1	2	3	4
22. I try to see it in a different light, to make it seem more positive.	1	2	3	4
23. I talk to someone who can do something concrete about the problem.	1	2	3	4
24. I sleep more than usual.	1	2	3	4
25. I try to come up with a strategy about what to do.	1	2	3	4
26. I get sympathy and understanding from someone.	1	2	3	4
27. I drink alcohol or take drugs in order to think about it less.	1	2	3	4
As a result of violence you have experienced, seen or heard about . . how much do you . . .	I Don't Do This At All	I Do This A Little Bit	I Do This A Medium Amount	I Do This A Lot
28. I give up the attempt to get what I wanted.	1	2	3	4
29. I look for something good in what is happening.	1	2	3	4
30. I think about how I might best handle the problem.	1	2	3	4
31. I pretend that it hasn't really happened.	1	2	3	4

32. I go to the movies or watch TV to think about it less.	1	2	3	4
33. I ask people who had similar experiences what they did.	1	2	3	4
34. I feel a lot of emotional distress and I find myself expressing those feelings a lot.	1	2	3	4
35. I take direct action to get around the problem.	1	2	3	4
36. I try to find comfort in my religion.	1	2	3	4
37. I reduce the amount of effort I was putting into solving the problem.	1	2	3	4
38. I talk to someone about how I feel.	1	2	3	4
39. I use alcohol or drugs to help me get through it.	1	2	3	4
40. I think hard about what steps to take.	1	2	3	4
41. I act as though it hasn't even happened.	1	2	3	4
42. I do what has to be done one step at a time.	1	2	3	4
43. I learn something from the experience.	1	2	3	4
44. I pray more than usual.	1	2	3	4

APPENDIX 1J:

LIFE STRESSES SCALES

Q23. We'd like to get a sense of the kind of stress that ***you*** may have experienced ***during the past year***. For the next list of items, I'd like you to tell me whether or not they happened in the last year, and ***if*** they happened, whether they caused minor stress or major stress. [NOTE: if the item has happened, but they say that it caused no stress, just select 'minor stress']

In the past year . . .	[1] No	[2] Caused Minor Stress	[3] Caused Major Stress
1. Have you moved?	1	2	3
2. Have you had medical problems with *(child)*?	1	2	3
3. Have you had medical problems with close family members?	1	2	3
4. Have you experienced the death of an important person?	1	2	3
5. Have you had a divorce, break-up, or separation from your partner?	1	2	3
6. Have you had a remarriage or reconciliation with your spouse or partner?	1	2	3
7. Have you had a parent-child separation including long hours at work?	1	2	3
8. Have you had a loss of income?	1	2	3
9. Have you had legal problems?	1	2	3
10. Have you had drug or alcohol problems or addiction?	1	2	3
11. Have you had stress or conflicts in the extended family?	1	2	3
12. Have you had pregnancies, miscarriages, or births?	1	2	3
13. Have you had job-related stress?	1	2	3

14. Have you had a loss of job?	1	2	3
15. Have you experienced crime or violent victimization?	1	2	3
16. Have you had unexpected expenses?	1	2	3
17. Has someone in your family had problems with police or court?	1	2	3
18. Have you had problems with where you live (for example, vandalism or not being able to get repairs done by your landlord)?	1	2	3
19. Have you had problems with your neighbors (for example, dogs barking or lots of noise at night)?	1	2	3
20. Have you had problems with people you owe money (for example, calls or letters from collection agencies, landlord threatening to evict you, people harassing you)?	1	2	3

Vita

Kathryn Reid-Quiñones was born on July 18, 1979, in Virginia, and is an American Citizen. She graduated from Culpeper County High School in Culpeper, Virginia in 1997. She received her Bachelor of Arts in Psychology from the University of Richmond in Richmond, Virginia in 2001. She began her graduate training in Developmental and Clinical Psychology at Virginia Commonwealth University in Richmond, Virginia in 2004.